

JUMP Application & Confidential Medical Form

Please provide complete answers to all questions

Trip Dates: _____ **Trip Type:** _____

Name: _____ Male Female

Phone #: Day (____) _____ Evening (____) _____ e-mail _____

Address: _____
Street City State Zip

Emergency Contact (Parent or guardian information if participant is under 18):

Name: _____ Relationship: _____ e-mail _____

Phone #: Day (____) _____ Evening (____) _____ Cell/Page (____) _____

Address: _____
Street City State Zip

Insurance Coverage: Participant is responsible for his or her own medical expenses. Insurance is required for participation. The information requested below is for the **primary family policyholder**.

Insurance Company: _____ Insurance Company Phone # (____) _____

Certificate/Policy/ID#: _____ Group # (if applicable) _____

Address: _____
Street City State Zip

Physician/Primary Care Provider's Name: _____ Phone # (____) _____

Medical and Physical Information:

Date of Birth: ____/____/____ Age: ____ Height: ____ Weight: ____ Date of Last Tetanus Booster: _____
MM DD YY

Exercise: detail your current activity below or indicate NONE.

<i>Activity</i>	<i>Frequency/Week</i>	<i>Approximate Time/Distance</i>	<i>Intensity Level</i>

SWIMMING ABILITY: Cannot Swim Can Swim 100 feet Can Swim 500 feet Strong Swimmer

ALLERGIES: Please list all allergies including medicines, food, bites, stings, shellfish, iodine, plants, and animals or indicate NONE

<i>Allergy</i>	<i>Reaction</i>	<i>Medication Required</i>

MEDICATIONS: Please list all prescription and non-prescription medication you take and/or carry with you or indicate NONE.

<i>Medication</i>	<i>Condition</i>	<i>Dosage (amount/frequency)</i>	<i>Initiated (month/year)</i>	<i>Side Effects</i>

DIETARY RESTRICTIONS: Please be specific (vegetarian, no red meat, lactose intolerant, allergies, celiac, strong food dislikes, etc.)

<<PLEASE COMPLETE THE REVERSE SIDE>>

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Health History: Please check the appropriate boxes, and respond to all questions below.

Please mark the space to the left of the question Y for Yes or N for No.

- | | |
|---|---|
| <input type="checkbox"/> 1. Operations/Serious Injuries in the past five years? | <input type="checkbox"/> 9. Neck/Back/Knee/Shoulder/Ankle problems? |
| <input type="checkbox"/> 2. Hospitalizations/Emergency visits in the last year? | <input type="checkbox"/> 10. Bleeding disorders, anemia? |
| <input type="checkbox"/> 3. Diabetes: Please note below if participant is insulin dependent. | <input type="checkbox"/> 11. Does participant smoke? |
| <input type="checkbox"/> 4. Epilepsy or seizure disorder: If yes, date of last seizure: _____ | <input type="checkbox"/> 12. Asthma or other respiratory problems? |
| <input type="checkbox"/> 5. Other past or current medical issues/illness/requirements? | <input type="checkbox"/> 13. Prescription Epi-pen? |
| <input type="checkbox"/> 6. Heart attack/By-pass surgery/Angioplasty/Angina/Unexplained fainting? | |
| <input type="checkbox"/> 7. Other cardiac conditions, including heart murmur or irregular heartbeat? | |
| <input type="checkbox"/> 8. High blood pressure, even if being treated with medication: If yes, list BP with date from last doctor's visit below. | |

IF PARTICIPANT IS UNDER 18, PLEASE COMPLETE THE FOLLOWING: Indicate Y for Yes or N for No

14. Has the participant had counseling with a psychiatrist/psychologist/counselor within the past two years? _____
If yes, is it currently ongoing? _____

Additional Emergency Contact (Other than parent or guardian listed on page one):

Name: _____ Relationship: _____ e-mail _____

Phone #: Day (____) _____ Evening (____) _____ Cell/Page (____) _____

If any of the boxes above were checked yes, please provide a description including history, symptoms, hospitalizations, and any restrictions. Please refer to the number listed by the issue above, and attach additional pages as necessary. Be sure to detail any medications on page one.

Identify and explain any physical or medical conditions not listed above which may affect or limit participation. (attach additional sheets as necessary): _____

Please read carefully:

- o Please review this form to be certain you have completed every question. This complete medical form is required for participation.*
- o All information on this form is confidential. Failure to disclose medical and health history information as requested could result in serious harm to you and other participants in your program.*
- o The status of your participation will be determined after review of this form. In some cases further evaluation, possibly including consultation with your health care provider, may be necessary.*

SIGNATURE REQUIRED

Consent is hereby given for the applicant to participate in the trip type described above on the dates indicated. I have enclosed full payment for the cost of the program or a deposit of \$50. I understand full payment is due 30 days prior to the departure date or reservations cannot be honored. **Refund policy:** Unless otherwise noted, a full refund is available for cancellations made 31 or more days prior to departure. A 70% refund will be given for cancellations occurring between 14 and 30 days prior to departure. Cancellations made less than 30 days prior to departure will not be refunded.

Permission is given for staff to obtain or provide medical care for me/my child, or to transport me/my child to a medical facility. I further authorize staff or medical personnel to render such treatment they consider necessary for my/my child's health and I agree to pay all costs associated with that care and transportation. I have read and understand both sides of this application and medical form and the information I have provided is, to the best of my knowledge, correct and complete.

Applicant's Signature

Date

Signature of parent/guardian (if applicant is under 18)

Date