TRAVERSE ALASKA

# Medical History Form

Each member of your party is required to complete a Medical History Form prior to trip departure. While Traverse Alaska has no intent of releasing any information provided, please recognize we may need to share medical information in the event of illness or injury on the trip.

By signing the Medical History Form, you are waiving your rights under the Health Insurance Portability and Accountability Act (HIPAA) and any state HIPAA laws.

| **Personal Information** | | |
|---|---|---|
| **Full legal name:** | **Date of birth:** | |
| **Height:** | **Weight (lbs):** | **Sex:** |
| **Address:** | | |
| **Phone:** | **Email Address:** | |
| **Emergency contact name:** | | |
| **Emergency contact relationship:** | | |
| **Emergency contact phone number:** | | |

Please use the table below to list any current medications (over the counter, prescription or herbal supplements) that you are taking.

| **Current Medications** | | |
|---|---|---|
| **Medication Name** | **Dose** | **Frequency** |
| | | |
| | | |
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| | | |

## Medical History

Have you ever or are you currently experiencing any of the following (please select all that apply):

- ☐ Allergies
- ☐ High blood pressure
- ☐ Heart disease/chest pain
- ☐ Stroke
- ☐ Ulcer
- ☐ Cancer
- ☐ Diabetes
- ☐ Surgeries or operations
- ☐ Chronic illness
- ☐ Asthma
- ☐ Headaches/dizziness
- ☐ Mouth/teeth problems
- ☐ Seizures
- ☐ Back pain
- ☐ Abdomen-hernia
- ☐ Hearing problems
- ☐ Cold weather injury (for example: frostbite)
- ☐ Eye/vision problems
- ☐ Blood disorders/anemia
- ☐ Constipation/diarrhea
- ☐ Emotional/mental illness
- ☐ Currently pregnant

Please provide additional details regarding any of the conditions you selected above. Be sure to describe any major operations, accidents or illnesses you have had in the past five year. If you have allergies, use the next table to describe them.

Please list any allergies (food, medication, animal, etc.) in detail below. Examples of reactions: rash, hives, trouble breathing, etc. For food allergies please also indicate if the allergy is triggered by ingestion or by airborne particles.

| **Name** | **Reaction** |
|---|---|
| | |
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| | |
| | |

| Consent for emergency medical or surgical care | |
|---|---|
| In the rare event of an emergency, I hereby give permission to the medical personnel selected by Traverse Alaska to provide routine health care; to administer medications; to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. All information is strictly confidential. Traverse Alaska does not cover accident insurance coverage for participants; you must carry your own accident insurance coverage.<br><br>I will assume the cost of necessary medical or surgical care. I authorize the following information for insurance purposes. | |
| **Name of primary physician**: | |
| **Physician phone number**: | **Clinic:** |
| **Insurance provider:** | |
| **Policy number**: | |

| Authorizations | |
|---|---|
| The information provided to Traverse Alaska on this form is provided for two reasons: 1. We may need the information on this form if you suffer an illness or injury on the expedition; 2. While we have no intention to release any of this information, please recognize that you are waiving your rights under the Health Insurance Portability and Accountability Act (HIPAA) and any state HIPAA laws. We may need to share your medical information if you suffer an illness or injury on the trip.<br><br>I HAVE READ THIS FORM AND I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE, AND THAT I HAVE DISCLOSED ALL RELEVANT HEALTH INFORMATION TO THE BEST OF MY KNOWLEDGE. | |
| **Signature of participant:** | **Date:** |
| *If the form is being completed for a participant under 18 years of age* | |
| **Name of participant:** | **Date:** |
| **Signature of parent or guardian:** | **Date:** |