Personal Health Inventory

River Watch Program
International Water Institute

The International Water Institute (IWI) encourages outdoor program participation. Our activities may operate in areas remote from hospitals and advanced medical support, with help possibly being hours away. Rescue may be difficult and expensive. Through rigorous pre-trip planning and by obtaining the most detailed and correct medical information possible from the trip participants, the potential of serious medical events can be minimized.

Please print clearly. All information will remain confidential.

Name_____
(Last) (First) (MI)

Address_____
(Street) (City) (State) (Zip)

Home Phone_____ Cell _____
(include area code)

Sex_____ Height_____ Weight_____ Birthdate_____
(Month/Date/Year)

Emergency Contact:

Name_____ Relationship_____

Address_____
(Street) (City) (State) (Zip)

Home Phone_____ Cell _____Work Phone_____

Do you have health insurance? Yes_____ No_____

Name of health insurance company_____

Policy number_____

NOTE: IWI does not provide health/medical insurance for course participants; you are responsible for health care costs incurred during the course of the trip.

Please list specific items after each question.

Please list all allergies (drugs, insects, food) _____

Are you currently taking any medications? Please list_____

Do you have any dietary concerns (vegetarian, lactose intolerance, food allergies)?

Explain_____

For your safety and the safety of other participants accurate information is needed on the items below.

Please check any conditions experienced within the last 5 years.

____Hearing problems
____Vision (glasses, contacts, blindness)
____Dizzy spells, fainting, convulsions
____Motion sickness
____Diabetes
____Neck or back problems
____Chronic pain (arthritis, muscle or joint stiffness)
____Other_____

____Broken bones, dislocations
____Chest pains or cardiac irregularities
____Shortness of breath, asthma
____High blood pressure
____Knee, shoulder, ankle or other joint problems
____Stomach, kidney, bladder, other internal problems

If you have answered yes to any of the questions above please explain below and include (continue on the back of this form as necessary):

1. Does this condition result in restrictions in your ability to perform any task?
2. What are the specific symptoms that you experience with this condition?
3. How often do symptoms or the condition occur and how severe are they?
4. How do you care for the symptoms of this condition?

_____
_____
_____
_____
_____

Do you have any other condition requiring the use of prescription drugs? If so, explain

_____

Other medical difficulties or health concerns?

_____

Have you been hospitalized in the last year? If so, please explain:

_____

Information Verification and Consent to Treatment

It is hereby verified that the above information is accurate to the best of my knowledge.

Furthermore, in the event that I should for any reason require any minor medical or surgical treatment and/or medication during the course of attendance at or participation in any IWI outdoor activity, I authorize such physician or medical staff as the IWI River Watch staff appoint or designate, to carry out the necessary treatment, or take me to the emergency room of the nearest hospital. I further authorize the hospital and its medical staff to provide treatment deemed necessary by them for my well-being.

_____

(Participant Signature) (Date)

_____

(Parent guardian signature- If participant is under 18) (Date)