EOU Outdoor Adventure Program
Health and Diet Questionnaire

Please return this form to:

Outdoor Adventure Program
1 University Blvd
La Grande, OR 97850
(541) 962-3621

This information is for the trip leaders' information only and is completely confidential

Name:_____OAP Trip: _____
Date of Birth: / /____Height:_____Weight: _____ Sex: Male Female
Address (at school):_____Phone (school): _____
Permanent Address:_____City: _____
State:_____Zip:_____Phone (permanent): _____
Emergency Contact:_____Relationship:_____
Emergency Contact Phone: ( )_____

OAP Trip Information

EOU Outdoor Adventure Program (OAP) trips can be multi-day wilderness expeditions in remote settings, where evacuation to modern hospital facilities is not immediately possible. You must expect extreme weather conditions ranging from snow storms to sleet to extreme heat and humidity. Sudden environmental changes are to be expected and anticipated. Depending on what activity you pursue in your OAP trip, you may be required to carry a heavy load up uneven, steep terrain; paddle for extended periods; sleep outdoors; experience long, tough days; and prepare meals and set up camp. Be sure that you are able to be responsible for yourself. If you have any questions about the activity and your participation you may contact the OAP.

Participant: Please circle YES or NO for each question. Each must be answered, but keep in mind that a "YES" answer does not necessarily mean you will not be able to attend your OAP trip.

General Medical History

Do you currently or have you ever had:

1. Respiratory problems? Asthma?	1. YES NO
2. Gastrointestinal disturbances?	2. YES NO
3. Diabetes or Hypoglycemia?	3. YES NO
4. Hypertension?	4. YES NO
5. Bleeding or blood disorders?	5. YES NO
6. Hepatitis or other liver diseases?	6. YES NO
7. Neurological issue? Epilepsy? Seizures?	7. YES NO
8. Dizziness or fainting episodes?	8. YES NO
9. Treatment or medication for menstrual cramps?	9. YES NO
10. Disorders of the urinary or reproductive tract?	10. YES NO
11. Do you see a Medical/Physical specialist of any kind?	11. YES NO
12. Are you pregnant?	12. YES NO
13. Treatment or counseling with a mental health professional?	13. YES NO
14. Cardiac problems?	14. YES NO
15. Anorexia/Bulimia/Eating Disorder?	15. YES NO
16. Heatstroke/Heat Exhaustion?	16. YES NO
17. Physical or Sensory Limitation?	17. YES NO
18. Any other health complaint?	18. YES NO

If you circled yes on any of the questions, 1-19, please provide a brief description of your condition and any associated physical limitations:

Muscle/Skeletal Injuries

Do you currently or have you ever had:
20. Knee, hip, ankle, shoulder, arm, back, or other injuries to muscles, tendons, ligaments, or bones (including sprains) and/or operations? If so, please explain:_____

_____

_____

Allergies/Medications

21. Any allergies? To insect bites or bee stings? 21. YES NO
If yes, please list them, along with their severity: _____

_____

_____

22. Are you allergic to any medications? _____ 22. YES NO

23. Are you currently taking any medications? 23. YES NO

Medication	Dosage	Side Effects/Restrictions

24. Year of last tetanus immunization:_____. If you cannot remember, was it within the past five years? 24. YES NO
A current tetanus immunization is recommended by the OAP.

25. Do you have a history of frostbite or Acute Mountain Sickness? 25. YES NO

26. Do you have a history of heat stroke or other heat related illness? 26. YES NO

Do you have any other physical, medical, or psychological conditions not listed above?

Fitness

27. Do you exercise regularly? 27. YES NO

Activity	Frequency	Duration/Distance	Intensity Level (easy/moderate/competitive)

28. Do you smoke? If so, how much? _____ 28. YES NO

29. Swimming ability (CHECK ONE): ___ Non-swimmer ___ Recreational ___Competitive

Diet

30. Do you have any dietary restrictions or food allergies? 30. YES NO
If yes, please describe (Are you vegetarian, vegan, gluten-free, or lactose intolerant? How strict are you? If you have a food allergy, what happens when you are exposed to the allergen?)

_____

_____

31. If you have dietary restrictions, please list some of the meals that you particularly enjoy: _____

_____

32. Please list any foods that you particularly despise: _____

_____

_____

PLEASE READ CAREFULLY AND SIGN

The information provided above is a complete and accurate statement of any physical and psychological conditions, which may affect my participation in this trip. I realize that failure to disclose such information could result in serious harm to me, and fellow participants. I agree to inform the EOU Outdoor Adventure Program (EOUOAP) should there be any change in my health status prior to the start of the trip. On the basis of the background information at the beginning of this form, and what I know or suspect about my physical and psychological health, I am fully capable of participating in this OAP trip. I understand that if I have the potential for a severe allergic reaction to bee stings, insect bites, food, poison oak, or other substances that might be found in the outdoor, it is my responsibility to bring the proper medication with me on this trip.

Participant's Signature: _____ **Date:** _____