MEDICAL HISTORY (Completed by SWU Outdoor Program participant)

			M F		
NAME: LAST	**FIRST**	**MIDDLE**	**GENDER**	**DATE OF BIRTH**	**SWU ID Number**

***PERMANENT* ADDRESS: STREET**	**CITY**	**STATE**	**ZIP CODE**	**RELATIONSHIP**

HOME PHONE:	Student mobile:	Parent mobile:

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP	ADDRESS	
HOME PHONE:	WORK PHONE:	CELL PHONE:	OTHER:

Note: The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. As needed, attach additional sheets for fuller explanations.

ALLERGY INFORMATION

List any food, drug, or contact allergies and type of reaction_____

_____

DO YOU REQUIRE AN EPI-PEN FOR ALLERGIC REACTIONS? YES_____ NO_____

(IF YES, YOU ARE REQUIRED TO BRING TWO (2) EPI-PENS FOR SWOOP.

HAVE YOU EVER HAD, OR DO YOU NOW HAVE : (check if applicable and indicate when and how long as well as any comments)

Condition	**Yes**	**Dates of occurrence, any other comments**
Chest pain with or after exertion		
Elevated blood pressure		
Dizziness with or after exercise		
Racing heart/irregular heart rhythm		
Heart murmur		
Fainting		
Anemia		
Asthma		Athletes: if on inhaler, bring one for trainer
Shortness of breath		
Pneumonia		
Seasonal allergies/sinusitis		
Strep throat		
Arthritis		
Any orthopedic injury (specify type)		
Surgery/rehabilitation		
Heat exhaustion or intolerance		
History of hypothermia		
Female: irregular or painful periods		
Male: testicular problem (testes)		
Urinary tract infection(kidney/bladder)		
Headaches/migraines		
Concussion		List how many_____ and dates of occurrence
Seizures/epilepsy		
Gall bladder disease or ulcers		
Diabetes		Insulin pump?
Hernia		
Irritable bowel syndrome		
Chronic diarrhea or constipation		
Weight problem: or recent gain/loss		

Condition	Yes	Dates of occurrence, any other comments
Mental health issues (specify)		
Learning disability/ADHD		
Anorexia/bulimia		
Bi-polar		
Depression		
Other :		
Chronic fatigue syndrome/fibromyalgia		
Sexually transmitted disease		
Cancer		
Thyroid disease		
Medically prescribed diet or fad diet		
Dental plates or orthodontics		
Tuberculosis		
Malaria		
Other		

Have you ever been hospitalized? _____ Specify and include dates:_____

Do you have any other medical/mental health concerns you wish to specify?

What kind of swimmer are you? Non-swimmer_____ weak_____ average_____ good_____ very strong_____

Do you exercise three or more times per week? Yes___ No___

Current medications (prescription or non-prescription)			
Name of med/vitamin, birth control pill, etc	Dosage	How long have you been on the medication?	Used for:

STATEMENT BY STUDENT OR PARENT/GUARDIAN (IF STUDENT IS UNDER AGE 18):

I have personally supplied (reviewed) the information on this two page history and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless by Court Order. However, if I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to Southern Wesleyan University to release information from my (son/daughter's) medical record to a physician, hospital, or other medical agency involved in providing me (him/her) with emergency treatment and/or medical care. I authorize copies of this medical record to be released to the athletic, physical education, and outdoor education departments, in accordance with requirements from those departments. I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by a licensed medical practitioner.

_____ _____

Signature of Student **Date**

_____ _____

Signature of Parent/Guardian, if student under age 18 **Date**