Health Form Questionnaire

As part of the registration process for each program offered by NCOAE, LLC, a North Carolina limited liability company d/b/a The National Center for Outdoor & Adventure Education ("NCOAE"), this Health Form must be completed and signed by either (i) the participant if the participant is an adult 18 years of age or older, or (ii) one parent or legal guardian of the participant if the participant is a minor under 18 years of age.

Confidentiality: Please answer each of the questions honestly and completely. This information will be shared with NCOAE staff, volunteers, contractors, or medical professionals, as necessary, to address the participant's health and medical issues. Otherwise, this information will remain confidential.

Participation in an NCOAE program includes a review of the participant's medical information. Medical information given on this form does not necessarily exclude participation, though we do reserve the right to refuse participation on medical or health grounds in certain cases. NCOAE needs accurate information about participant's health to understand any health concerns or issues. In the event of an injury or illness, this form provides medical personnel with critical medical history. The participant, parent (if applicable), and the participant's physician should consider carefully whether the NCOAE program is an appropriate match for the participant. All NCOAE participants must understand that they share in the responsibility for their own well-being and the well-being of others on the program.

Program Description: NCOAE programs take place in the U.S. or in foreign countries and participants may engage in a variety of educational, adventure, or recreation activities in remote, urban, mountainous and ocean environments. Activities vary from program to program, and take place in a variety of environments on both land and water, in hot and cold weather, under humid or dry conditions and at sea level or higher elevations. Activities may take place in remote areas where medical care may be delayed, and medical services and facilities may be primitive or inadequate.

Please consider this information as you complete this form. You may review the NCOAE Acknowledgment and Assumption of Risks & Release and Indemnity Agreement for additional details about these activities and the associated risks. Please contact us with any questions.

1. Participant Information:

Full Name:			
Address:			
Email:		**Phone:**	**Cell:**
Date of Birth:	**Gender:**	**Height:**	**Weight:**
Shoe Size:	**Shirt Size:**	**Pant Size:**	

2. Allergies. List all known allergies (including those related to medication, food, insect bites or stings, animals, pollen, plants dust, or other). For each allergy, identify the type of reaction, management of the reaction, and date the last reaction incurred.

3. Medical Conditions.

Is the participant currently suffering, or has the participant ever suffered, from any of the following?	YES	NO
Heart/circulatory disease?	☐	☐
High blood pressure?	☐	☐
Asthma, bronchitis, pneumonia, or other respiratory condition?	☐	☐

continued

Is the participant currently suffering, or has the participant ever suffered, from any of the following? *cont.*	**YES**	**NO**
Digestive/bowel disorder?	☐	☐
Diabetes?	☐	☐
Epilepsy, seizures, and/or fainting attacks?	☐	☐
Migraines?	☐	☐
Head injury?	☐	☐
Bone fractures or back injury?	☐	☐
Auto-immune or other chronic disease?	☐	☐
Cartilage (tendon or ligament) damage?	☐	☐
Arthritis, bone, joint, or muscle injury or problems?	☐	☐
Hospitalization and/or any surgical procedures within the last year?	☐	☐
Recent exposure to an infectious disease?	☐	☐
Medical condition(s) that may be affected by conditions such as humidity, heat, extreme cold, or air pollution?	☐	☐
Difficulties at altitude?	☐	☐
Mental or emotional instability, including depression or suicidal thoughts?	☐	☐
ADD, ADHD, autism spectrum, or other learning disability?	☐	☐
Substance abuse?	☐	☐
Eating disorder or self-abuse?	☐	☐
Significant hearing or vision impairment?	☐	☐
Is the participant pregnant?	☐	☐
Has the participant recently been seriously ill?	☐	☐

4. If you answered 'yes' to any of the above, please give details below.

5. In the last two years, has the participant been in therapy or treatment with a psychiatrist, psychologist, or counselor for any reason? If yes, please explain reason for treatment.

6. In the last two years, has the participant been expelled or dismissed from school or a summer program? Please describe.

continued

7. Is the participant currently under a physician's care? If so, please explain?

8. Does the participant have any condition/s or limitation/s (*e.g., mental, physical, or emotional*), described above or otherwise, which might affect the participant's well-being, the well-being of others, or limit the participant's ability to engage in NCOAE activities? **Yes** ☐ **No** ☐

   If you answered 'yes' above, please describe (include any adaptations or modifications you believe may be appropriate or necessary):

9. Is the participant on any kind of a special or restricted diet? If so, please explain.

10. Are the participant's routine U.S. vaccinations up to date? These include measles/mumps/rubella (MMR) vaccine, diphtheria/pertussis/tetanus (DPT) vaccine, varicella (chicken pox), poliovirus vaccine, etc.
    Yes ☐ **No** ☐

    If 'no', please explain:

11. The date of participant's last Tetanus shot was: _____

12. If required by your program, please indicate if the participant has had any additional vaccinations such as Hep A, Hep B, Typhoid, Yellow Fever, flu, Covid-19, etc. If participant receives any vaccinations after initially completing this form, please email updates to info@ncoae.org so that we can update our records.

Vaccination (indicate number of courses if applicable)	DATE

Medication Warning and Policy: Use of prescription and non-prescription drugs is a matter that NCOAE takes very seriously. The abuse of prescription and even over-the-counter medications is significant problem in our society. Risks include, but are not limited to, participants bringing undisclosed drugs; swapping, selling or trading their medications with other program participants; overdosing and other adverse reactions. For this, and other reasons, before the start of the program, we require all minor participants to deliver their medications (prescription, over the counter, herbal), to NCOAE staff or school/organization personnel, as applicable. Certain medications may be left in the participant's possession at NCOAE's discretion, such as acne medication or asthma inhalers, and other medications may be held by staff. In either case, participants must understand how to responsibly use and administer their medications, per their physician's instructions.

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13. Please list all prescription, over-the-counter, and natural medications participant is taking now or will be taking during the NCOAE program (whether for regular or episodic use).

Medication Name	Dosage	Frequency	Side Effects/Effects of Missed Dose (known and potential)	Reason for Taking

14. Are there any medications taken in the ordinary course that participant will/may not take during the program? If so, please describe:

_____

_____

_____

15. What is participant's swimming ability in deep water (5 feet or more)? Consider participant's comfort level and physical condition. **Poor or non-swimmer** ☐ **Swims comfortably** ☐

**Please let us know if you have any specific concerns about participant's participation in swimming or water based activities, and/or if participant has a fear of the water.*

16. Is there any other information about participant, medical or other, that we should know?

_____

_____

_____

17. Emergency Contact Information

Full Name:		
Address:		
Relationship:		**Email:**
Daytime Phone:	**Evening Phone:**	**Mobile Phone:**

If the person above is unavailable, please also contact

Full Name:		
Address:		
Relationship:		**Email:**
Daytime Phone:	**Evening Phone:**	**Mobile Phone:**

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18. Insurance Information

Insurance Carrier:	
Address:	
Employer Name, if applicable:	**Phone:**
Policy Number:	**Group Number:**

19. If participant has signed up for an international program, I have verified that the above insurance policy will cover participant's long-term U.S. care for an accident or illness that happens overseas.
Yes ☐ **No** ☐

For some international trips, NCOAE may have emergency medical and evacuation insurance to cover short-term, immediate coverage overseas and necessary evacuations. NCOAE's insurance may not cover all medical costs overseas, nor will it cover any follow-on medical care in the U.S. These additional medical costs must be covered by the participant's insurance. NCOAE does not guarantee that its insurance will cover any incident. Participants should consider securing their own travel insurance. Call NCOAE if you have any questions or need other insurance options.

ACKNOWLEDGMENT and AGREEMENT:

To the best of my knowledge, this Health Form contains true and accurate information. I understand the nature of NCOAE activities, and acknowledge that I can contact NCOAE should I have any questions about these activities or their mental, physical, or emotional demands. Other than any limitations described in this form, I represent that participant is fully capable of participating in the program, without causing harm to themselves or others. Participant agrees, and has permission from their parent/s if they are a minor, to participate in all NCOAE activities. I agree to contact NCOAE if any medical or health condition (including pregnancy) changes before the start of (or during) the NCOAE program. I understand that providing inaccurate medical or health information or falsifying medical or health information can create serious risks to the participant or others, can invalidate medical insurance, and/or can result in the participant's dismissal from the program. I understand the participant's ability to participate is contingent upon NCOAE representatives' review of all forms, including this one. I understand that although NCOAE will review this information and may allow participation, NCOAE cannot anticipate or eliminate risks or complications posed by a participant's mental, physical, or emotional condition. I understand that emergency, medical, drug and/or health issues, response, assessment, or treatment are included within the scope of — and expressly subject to the terms of — the NCOAE Acknowledgment and Assumption of Risks & Release and Indemnity Agreement.

Participant Name *Print Name* _____ Participant birthdate _____

Adult Participant or Parent (*i.e., parent or legal guardian*) of a Minor's Signature _____ Date _____

Signatory's Name Here *Print Name* _____

continued

MEDICAL AUTHORIZATION/CONSENT TO TREAT:

I authorize NCOAE staff, representatives or other medical personnel to obtain or provide medical care for me/my minor participant, to transport me/my minor participant to a medical facility, and/or to provide treatment (including, but not limited to hospitalization, medications, injections, anesthesia, or surgery) they consider necessary for my/my minor participant's health. I agree to the release (to or by NCOAE) of any records, including this Medical Form, necessary for treatment, referral, billing, or insurance purposes. (I agree this form may be photocopied for use in the field).

Signature Required: The adult participant must sign below. If the participant is a minor, at least one parent or legal guardian must sign below. The person signing below understands that whether they choose to electronically sign and accept, or sign a printable version of the Health Form, they are entering into a legally binding contract with NCOAE.

Participant Name *Print Name*

Participant birthdate

Adult Participant or Parent (*i.e., parent or legal guardian*) of a Minor's Signature

Date

Signatory's Name Here *Print Name*