Medical Form

Instructions for Completing this Form

- Please complete and sign this form and return it to your trip leader within 30 days of registering for the trip.
- Minor participants (those under 18 years old) must complete the form with a parent/legal guardian (collectively "parent").
- Please review the trip brochure, trip Essential Eligibility Criteria (EEC) and the Participant Responsibility and Information Form responsibilities and disclosure in conjunction with completing this form. It is critical that you provide honest, accurate and complete information. The Sierra Club requests this information to assist Leaders in understanding health issues, to consider potential modifications and for use during emergencies. This information may be shared with Sierra Club Leaders/other staff, medical professionals or others, as necessary, to address participant's health and medical issues. Otherwise this information will remain confidential.
- Use a separate sheet if needed.

General Information

Trip number:

Full name:

Age: **Date of birth:**

I identify my gender as:

Height: **Weight:**

Blood pressure: /

Resting heart rate: **bpm**

Address:

City: **State:** **ZIP:**

Mobile phone: ( )

Home phone: ( )

Primary Emergency Contact:

Relationship:

Phone: ( )

Travel and Medical Insurance

We strongly encourage you to have travel and medical insurance and to bring your insurance card or other documentation with you on the trip.

Travel Insurance

Company name:

Policy number/coverage amount:

Contact phone number: ( )

Medical Insurance

Company name:

Policy number:

Contact phone number: ( )

Allergies

Include allergies to food, insect bites and stings, medicines, animals, and the environment (dust, pollen, etc). Use a separate sheet if needed.

Select if no allergies

Allergy	Reaction	Medication required (e.g. epipen, antihistamine)	Is your allergy serious or life-threatening? How so?

Medications

Please list all prescriptions, over the counter, natural medications, medical marijuana and inhalers you are currently taking. Include prescription medications taken for episodic or emergency use. Note if this is a recent change in dosage or prescription. Use a separate sheet if needed.

Select if no medications

Medication name	Dosage	Frequency	Current side effects	Reason for taking (symptom/condition)

General Medical History

Please complete the following medical history questions. If answering YES, use the box provided or a separate sheet to explain history in more detail and note if the medical condition has been a problem in the past 12 months. Do you currently have, or have you had a history of:

Asthma or other respiratory issues: **Yes** **No**

Sleep apnea: **Yes** **No**

Do you use a Continuous Positive Airway Pressure (CPAP) machine? **Yes** **No**

Diabetes (type 1 or 2):	**Yes**	**No**
Gastrointestinal issues:	**Yes**	**No**
Cardiac issues or hypertension:	**Yes**	**No**
Neurological issues:	**Yes**	**No**
Seizures:	**Yes**	**No**
Memory issues:	**Yes**	**No**
Vision or other eye issues:	**Yes**	**No**
Hearing issues:	**Yes**	**No**
Bone, joint, muscle issues:	**Yes**	**No**
Any procedure, surgery, or replacement of a joint, muscle tendon, or bone:	**Yes**	**No**
Head trauma, traumatic brain injury:	**Yes**	**No**
Do you smoke or use tobacco?	**Yes**	**No**
Do you smoke or use marijuana?	**Yes**	**No**
Do you drink alcohol?	**Yes**	**No**
Have you been diagnosed or are you seeking treatment for anxiety, depression, substance abuse, or other mental health issues?	**Yes**	**No**
Are you pregnant?	**Yes**	**No**
Have you had any serious illness in the past 6 months?	**Yes**	**No**
Have you had surgery or been hospitalized in the last year?	**Yes**	**No**
Have you ever had problems related to exposure to altitude?	**Yes**	**No**

Are there any other conditions or limitations (mental, emotional, or physical) that may affect your participation on this trip? If yes, please explain. **Yes** **No**

What is your swimming ability in deep water (5 feet or more)? Consider your ability, comfort level and physical condition. **Competent** **Poor** **Non-swimmer**

Have you had a tetanus shot within the last 10 years? **Yes** **No**

Date of most recent physical: **Medical provider's name:**

Address: **Phone: ( )**

Coronavirus Addendum

Reducing the risk of COVID-19 transmission to other participants, trip leaders and further, to the communities that we visit is a goal we all share. This screening will not identify people who may be infected but not yet showing symptoms or those who may be infected but simply do not show symptoms ("asymptomatic"). We ask that you complete the following questions to help lessen the spread of COVID-19.

Have you been fully vaccinated against COVID-19? **Yes** **No**

If yes, when?

DAY/MONTH/YEAR

Have you received a booster vaccine? **Yes** **No**

If yes, when?

DAY/MONTH/YEAR

Note: Vaccination against COVID-19 does not change the importance of your need to continue to follow public health guidance for physical distancing, wearing face coverings, hand-washing and avoiding high-risk situations. ***Review local guidance and CDC resources***.

In order to limit your potential exposure to the virus pre-trip we ask that you minimize your non-essential activities outside of your home in the 2 weeks before your travel date. Work, outside exercise, and grocery store visits are examples of essential activities. Going to a restaurant or bar or social activities with people with whom you do not share a household are considered non-essential. This applies whether or not you have been vaccinated.

If within 2 weeks before your travel date you are diagnosed with COVID-19, develop COVID-19 like symptoms or are in close contact with someone who tested positive you will be required to cancel from the outing. Close contact is defined as within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period starting from 2 days before illness onset (or, for patients without symptoms, 2 days prior to test specimen collection) until the time the patient is isolated. Or being coughed or sneezed on by an infected person, or someone in your household tested positive. A negative COVID test will not negate this requirement.

List of COVID-19 Symptoms (from CDC)

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea, vomiting, or diarrhea

The pandemic is a fluid situation. Knowledge, protocols and guidelines can change. Any changes to the requirements listed in this addendum will be communicated to you by the trip leader.

Travel to international destinations may have different requirements for entry to the country. Your trip leader will share those requirements with you.

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Participant (and Parent of a Minor Participant), please sign and date below:

I certify that the information provided above is true, complete, and accurate. Other than any limitations described in this form, or any other information I have provided, I agree I (or my child) can participate in all trip activities. I agree to contact the Sierra Club promptly to provide additional information if my (or my child's) medical or health condition changes before the start of or during the trip. I acknowledge that falsifying or providing inaccurate or incomplete medical information can create serious risks to me or my child or to others and may result in dismissal from the trip. I reaffirm the Participant Responsibilities agreed to in my Participant Responsibilities and Information Form. I understand my (or my child's) final acceptance in the trip is contingent upon Sierra Club leader receipt and review of all required forms and information.

Trip name and dates:

Participant signature:

Print name: **Date:**

Parent or Legal Guardian signature
(if participant is a minor):

Print name: **Date:**