### Offsite Research Activity Medical Form

The information you provide below will be kept confidential and only shared with health care professionals providing care to you.

**Personal Information:**

Your Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other means of communication while offsite (i.e., apps, social media messaging):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your level of medical training (e.g. CPR, Basic First Aid, WFR, etc)

**Emergency Contact 1:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact 2:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**

Do you have a history of any of the following? (please circle relevant issues and explain below)

Diabetes

High blood pressure

Heart disease/ murmur/ chest pain

Asthma

Lung or respiratory disease

Ear/eye/nose/sinus issues

Musculoskeletal issues

Head injury/concussion

Altitude sickness

Psychiatric or emotional issues

Behavioral/neurological issues

Blood disorders

Fainting spells/dizziness

Kidney disease

Seizures

Abdominal/gastronomical issues

Thyroid disease

Excessive fatigue

Sleep disorders

Any medical issues in the past 3 years:

Current medical issues:

Family history of any of the above:

**Mental Health Information:**

Do you have a history of any of the following: please circle relevant issues and explain below

Medications

Outpatient Counseling

Day Treatment

Psychiatric Hospitalization

Residential Treatment

Do you have any cognitive, sensory, or emotional condition(s), e.g. anxiety, ADD, depression, or learning disabilities, that would require special consideration or accommodation?

Have you experienced any recent emotionally traumatic experiences, such as a death of family or friends, in the past year?

**Allergies:**

Do you have allergies to any foods, medications, insects, plants, skin products (e.g.sunscreen)? If so, please describe the symptoms, severity and treatment

**Medications:**

Do you take any medications regularly? Please describe the reason for taking the medication, dosage, frequency, side effects, issues if you miss a dose, special considerations (e.g. epi-pens need to stay above freezing) etc.

**Please bring double your normal quantity in case of damage or loss of your medication.**

**Immunizations:**

The following immunizations are recommended by the CDC for travel to \_\_\_\_\_\_\_\_\_.

…

…

…

…

Additionally, the CDC suggests that you consult your doctor to decide whether you want to get vaccinated against … .