

YOUTH ODYSSEY

Medical Release and Health History Questionnaire

Although the activities we participate in are relatively safe for most apparently healthy individuals, the reaction of the cardiovascular system to increased levels of physical activity cannot always be totally predicted. Consequently, there is a small but real risk of certain changes occurring during physical activities. Some of these changes may include abnormal blood pressure, irregular heart rhythm, fainting, and in rare instances, a heart attack or cardiac arrest. **Therefore, it is imperative that you provide honest answers to this questionnaire.** Physical activity may be contraindicated under some of the indications listed below. Others may simply require special consideration. Be sure to promptly report to Youth Odyssey, Inc. staff any exercise related abnormalities that you may experience during any physical participation.

Please answer YES or NO to the following questions:

Have you ever had or do you now have any of the following heart or heart-related conditions:

- | | | |
|---|--|--|
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Chest pain at rest or during physical activity | <input type="checkbox"/> Uneven/Irregular Heartbeats |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Any other heart problem that makes physical activity unsafe | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatic Heart Disease | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Stroke | | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Diabetes | | |

Please explain any questions that were answered YES:

Do you suffer from any of the following conditions?

- | | | |
|--|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Any Allergies, FOOD, BEES etc. | <input type="checkbox"/> Any other physical disabilities that could interfere with safe participation in physical activities |
| <input type="checkbox"/> Any joint, bone or muscle problems | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Chronic Low Back Pain | |
| <input type="checkbox"/> Any respiratory diseases, i.e. Asthma | <input type="checkbox"/> Mononucleosis | |
| | <input type="checkbox"/> Do you smoke? | |

Please explain any questions that were answered YES:

Please list any medications that you are taking and indicate the reason(s) for taking:

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- | | |
|--|--|
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Epinephrine Injector (Allergic Reactions) |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Iodine Swabs |
| <input type="checkbox"/> Bactine | <input type="checkbox"/> Burn Cream |
| <input type="checkbox"/> Poison Oak and Ivy Cleanser | <input type="checkbox"/> Antibiotic Ointment |
| <input type="checkbox"/> Poison Absorbent | <input type="checkbox"/> Suntan Lotion with SPF |
| <input type="checkbox"/> Neosporin | <input type="checkbox"/> Burn Cream/Lotion/Gel |
| <input type="checkbox"/> Benadryl | |

Youth Odyssey Staff must be informed if the said youth has any allergies or physical or emotional maladies prior to partaking in an activity. I, (Parent/Guardian) _____ understand that the aforementioned medications are the only ointments or tablets which Youth Odyssey carries in their first aid kit. I, (Parent/Guardian) _____ give Youth Odyssey permission to administer any and all of the above-mentioned medications if and when necessary.

I, the Parent/Guardian of (participant) _____ give my consent for emergency medical and/or surgical treatments for (participant) _____ in a licensed hospital/clinic by a licensed physician should the condition require it in my absence. I understand that in such case, reasonable attempts would first be made to contact me by Youth Odyssey, Inc. Staff with time and conditions permitting.

Name of Doctor: _____ Phone: _____

Medical Insurance Co: _____ Policy No: _____

Signature of Participant (Youth)

Signature of Youth Odyssey Staff

Signature of Parent/Guardian

Date