campusrec
BINGHAMTON UNIVERSITY

Campus Recreational Services
Binghamton University
PO Box 6000, East Gym
Binghamton, NY 13902

Outdoor Pursuits Medical History Form

Participation in an Outdoor Pursuits class or activity requires that all medical information below be completed and submitted to the BOP Office. This information is needed to provide better first aid and emergency medical care should that be necessary. All information is reviewed upon submission and remains confidential. After review , you may be asked to provide appropriate physician documentation prior to beginning activity or at any time in the future as necessary. Please answer **ALL** questions as completely and accurately as possible.

Name (Please Print): ______________________________ Class Status: Fr. Soph. Jr. Sr. Grad. Other

Date of Birth: ______________________ Sex: M____ F____ Height: ________ Weight: ______

Person to be contacted in case of emergency: ______________________________

Phone (daytime): ____________________ (Evening): ____________________ Relationship: ________________

Address: ________________________ City:____________________ State & Zip: ________________

	Yes	No
Allergy		
Drugs:	☐	☐
Food:	☐	☐
Environmental:	☐	☐
Insects:	☐	☐
Other:______________________		
Diabetes:	☐	☐
Disease or Injury of Back, Joints:	☐	☐
Dizziness, Fainting:	☐	☐
Emotional Problems		
Anxiety (frequent):	☐	☐
Depression (frequent):	☐	☐
Insomnia:	☐	☐
Head Injury with Unconsciousness:	☐	☐

	Yes	No
History of concussions:	☐	☐
Heart Disease or Rheumatic Fever:	☐	☐
Heart Palpitations:	☐	☐
High Blood Pressure:	☐	☐
Respiratory Problems		
Asthma:	☐	☐
Cough:	☐	☐
Ear, Nose Throat Trouble:	☐	☐
Seizure Disorder:	☐	☐
Shortness of Breath:	☐	☐
Surgery ______________________		

Has your physical activity restricted during the past five years? (Give reasons and durations) Yes_____ No_____

Have you received treatment or counseling for a nervous condition, personality or character disorder or emotional problem? (Give details below) Yes_____ No_____

Are you now under treatment for any medical or emotional condition? Yes_____ No_____

Are there any restrictions on physical activity related to classes or sports? Yes_____ No_____

Please list all prescription medications you will take on trips or activities: ______________________________

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Please provide additional information on any boxes checked "Yes" above:

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____

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X ____

Students Signature Date

This information is strictly for the use of the Department of Campus Recreation and may not be released to anyone outside the department without your written consent.