

Confidential Health Assessment Form

Personal and Emergency Contact Information (to be completed by the student):

Name: (last) _____ (first) _____

Permanent address (include city): _____

Telephone: _____ Date of Birth: (dd/mm/yr): _____

Provincial Health #: _____ Province of Health Plan: _____

Private Health plan (Co. and Policy #): _____

Emergency Contact Information:*(A more thorough Contact Information Form will be completed by successful candidates in the first week of school.)**In case of emergency, please contact on my behalf:*

Name: _____ Relationship: _____

Phone: (_____) _____

Note to the student:

This health assessment form is part of your application process, and it is your responsibility to ensure it is completed and returned accordingly. Any costs incurred regarding the completion of this form are your responsibility, regardless of your acceptance into any Algonquin College Program. Any medical points of concern may be followed up by telephone by the Program Coordinator.

The information contained on this form is confidential, and will not be released without your written consent. The information is protected under the Freedom of Information and Protection of Privacy Act and will be utilized only for the purposes related to Algonquin College's Application process and policies on Risk Management. Specific skills course instructors may be informed of your medical history if there are safety concerns and their knowing is in your best interest.

The information you provide in the following pages must be a complete and accurate statement of the physical and psychological factors which may affect your successful participation in the Program. Failing to disclose such information could result in serious harm to yourself and fellow students and may result in your non-acceptance to or removal from the Program. By signing this form, the student agrees to indemnify and hold Algonquin College harmless if all relevant information is not disclosed.

Please sign here indicating you have read and agree to the statements above.

Signature: _____ Date: _____

STEPS TO FOLLOW:

- Mail or fax the completed Confidential Medical Form **BEFORE** the date of your Program Readiness Camp (if you are a 2-year Outdoor Adventure student), OR before July 15 (if you are an Outdoor Adventure Naturalist student). Students cannot participate in any Adventure Activities without a submitted medical form.
- Mail to: Attn Outdoor Adventure or Outdoor Adventure Naturalist Selection Committee
Algonquin College
315 Pembroke Street East
Pembroke, ON K8A 3K2
Fax: (613) 735-4739; emailing a PDF version to the Program Coordinator is also accepted.

Algonquin College Adventure Programs Information for the Medical Physician

The Algonquin College Adventure Programs train students to be leaders and guides in the adventure travel industry. Training is a combination of in-class study and out-of-doors activity. The outdoor training ranges from single-day to nine-day expeditions, and takes place in remote settings where evacuation to modern medical facilities could take days.

The student will live and train in extreme conditions ranging from -40C to +25C and be exposed to wind and snow, sudden immersion in cold water and/or high seas. Depending on the specific course type, students will carry 50-75 pound packs over uneven terrain, swim whitewater rapids, and portage heavy boats. On a number of occasions the students will be eating and sleeping out of doors. It is expected that each student takes good care of him or herself.

Most students find the Algonquin College Adventure Programs both physically and mentally demanding. As such, prior physical conditioning and an enthusiastic mental attitude are a necessity.

In the interest of personal safety of both the applicant and the other students, please consider carefully the above description when completing the Medical Form. A 'yes' answer will not automatically cancel a student's enrollment. If we have any question regarding a student's capacity to be successful in this program, we will call that student to discuss that concern. The medical professional completing this form may not be a relative of the applicant.

Your detailed comments will expedite our review of this Confidential Health Assessment Form.

MEDICAL PHYSICIAN'S NAME: _____

Telephone: (____) _____ Address: _____

PHYSICIAN: Please circle YES or NO for each item, explain any YES answers in the space provided.

GENERAL HISTORY: Does the applicant have currently or a history of:

- | | | | | |
|-----|---|-----|----|-------|
| 1. | Respiratory problems? Asthma? | Yes | No | _____ |
| 2. | Diabetes? | Yes | No | _____ |
| 3. | Bleeding or blood disorders? | Yes | No | _____ |
| 4. | Hepatitis or other liver disease? | Yes | No | _____ |
| 5. | Neurological problems? Epilepsy? | Yes | No | _____ |
| 6. | Seizures? | Yes | No | _____ |
| 7. | Migraines, dizziness or fainting? | Yes | No | _____ |
| 8. | Cardiac problems? | Yes | No | _____ |
| 9. | Treatment/medication for menstrual cramps? | Yes | No | _____ |
| 10. | Disorders of the urinary or reproductive tract? | Yes | No | _____ |
| 11. | Any other disease? _____ | | | |
| 12. | Does this person see a specialist of any kind? | Yes | No | _____ |

MUSCLE/SKELETAL INJURIES: Does the applicant have currently or a history of:

- | | | | | |
|-----|--|-----|----|-------|
| 13. | Knee, hip or ankle injuries (include operations) | Yes | No | _____ |
| 14. | Shoulder or arm injuries (include operations) | Yes | No | _____ |
| 15. | Back injury (include operations) | Yes | No | _____ |



For office use: Initial review: OK Check further
Detailed review: OK Date:_____

- 16. Head injury? Yes No _____
- 17. Other joint problems? Yes No _____
- 18. History of frostbite/Raynaud's Syndrome? Yes No _____

PERSONAL HISTORY (COUNSELING / PSYCHIATRIC):

- 19. Has he/she had treatment or counseling with a mental health professional? Yes No (if NO, skip to #25)_____
- 20. Is he/she currently in treatment/counseling? Yes No _____
- 21. Name/phone of therapist:_____
- 22. Hospitalization in the past year? Yes No _____
- 23. Reasons for treatment or counseling?_____
- 24. Will the applicant's condition interfere with his/her success in this program? Yes No _____

ALLERGIES and MEDICATION:

- 25. Any allergies? Yes No _____
- 26. Have allergies ever threatened your health? Yes No _____
- 27. We treat drinking water with iodine and/or Chlorine dioxide. Is this a problem? Yes No _____
- 28. Are there any diet restrictions? Yes No _____
- 29. Is he/she allergic to any medications? Yes No _____
- 30. Is he/she currently taking any medication? Yes No _____
- 31. Specify Med/Dosage/Restrictions:_____

FITNESS:

- 32. Does the applicant exercise regularly? Yes No _____
- 33. Specify activity/frequency/duration/intensity_____
- 34. Swimming ability (check one): non-swimmer recreational competitive
- 35. Blood pressure:_____Pulse:_____
- 36. Height(ft):_____Weight(pd):_____

DO YOU BELIEVE THIS PERSON CAN SUCCESSFULLY PARTICIPATE IN THIS DEMANDING PROGRAM?

YES NO

PHYSICIAN'S SIGNATURE:_____Date:_____