



ROTARY YOUTH EXCHANGE SKI TRIP - 2010

HEALTH EVALUATION FORM

FORM 3 OF 3

Name: _____

Activities while on the ski trip are generally comparable to those experienced in high school, including physical education activities. Some activities may be very strenuous and altitude and weather are always a factor. The trip chaperones MUST know of any physical limitations, medications or recent medical treatments or surgeries that may affect each participant's welfare. While this will not limit their participation, special precautions can be taken to ensure their safety.

Please check all items listed below with Yes or No. If Yes, please give a brief description of the problem:

- | YES | NO | |
|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | FREQUENT OR SEVERE HEADACHES |
| <input type="radio"/> | <input type="radio"/> | DIZZINESS OR FAINTING SPELLS |
| <input type="radio"/> | <input type="radio"/> | UNCONSCIOUSNESS FOR ANY REASON |
| <input type="radio"/> | <input type="radio"/> | EYE TROUBLE <i>(not correctable with glasses)</i> |
| <input type="radio"/> | <input type="radio"/> | HEART TROUBLE |
| <input type="radio"/> | <input type="radio"/> | HIGH OR LOW BLOOD PRESSURE |
| <input type="radio"/> | <input type="radio"/> | CRONIC OR RECENT EAR TROUBLE |
| <input type="radio"/> | <input type="radio"/> | SIGNIFICANT ABDOMINAL TROUBLE <i>(including hernia)</i> UNLESS CORRECTED |
| <input type="radio"/> | <input type="radio"/> | EPILEPSY |
| <input type="radio"/> | <input type="radio"/> | HEAD INJURY |
| <input type="radio"/> | <input type="radio"/> | NERVOUS TROUBLE OF ANY SORT |
| <input type="radio"/> | <input type="radio"/> | ASTHMA OR ANY BREATHING DISORDER |
| <input type="radio"/> | <input type="radio"/> | INJURIES <i>(requiring hospitalization)</i> OR SURGERY WITHIN THE LAST 5 YEARS |
| <input type="radio"/> | <input type="radio"/> | ANY ALLERGIES <i>(including allergies to medications)</i> |
| <input type="radio"/> | <input type="radio"/> | DIABETES OR HYPOGLYCEMIA |
| <input type="radio"/> | <input type="radio"/> | CURRENT MEDICATIONS <i>(please list below)</i> |
| <input type="radio"/> | <input type="radio"/> | OTHER <i>(please specify any medical conditions not listed above)</i> |

IF YES ON ANY OF THE ABOVE PLEASE DESCRIBE HERE:

I hereby certify that to the best of my knowledge and belief the health of the above listed person is as shown.

Signature (Please indicate appropriate signature block below) Date

Host Parent _____ Counselor _____ Parent _____ Chaperone _____