

Health Questionnaire and Medical Release Agreement

In order to assist us in facilitating medical treatment, in the case of medical emergency, you may wish to voluntarily provide BYU-Idaho with the following information:

1. Have you had any of the following ailments? Check if yes and give details below (under item 5).

- | | | |
|---|--|---|
| <input type="checkbox"/> Surgical Operations | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hearing Problem |
| <input type="checkbox"/> Serious Accident | <input type="checkbox"/> Internal Injuries | <input type="checkbox"/> Ear Trouble, Discharge |
| <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Injury, Either Eye | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Back Injury | <input type="checkbox"/> Eye Disease |
| <input type="checkbox"/> Pneumonia, Pleurisy, Bronchitis | <input type="checkbox"/> Dizziness, Fainting Spells | <input type="checkbox"/> Headaches, Severe or Often |
| <input type="checkbox"/> Frequent colds, Sinusitis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Kidney Stone or Colic | <input type="checkbox"/> Asthma, Shortness of Breath | <input type="checkbox"/> Osteomyelitis |
| <input type="checkbox"/> Dropsy, Bladder, Kidney Disease | <input type="checkbox"/> Congenital Abnormalities | <input type="checkbox"/> Head Injuries |
| <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Skin Disease of Any Kind | <input type="checkbox"/> Arm or Leg Injury |
| <input type="checkbox"/> Epileptic Seizure, Convulsion, Paralysis | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Foot Trouble |
| <input type="checkbox"/> Jaundice, Gall Stones, Disease of Liver | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Vomiting or Passing of Blood |
| <input type="checkbox"/> Malaria, Typhoid Fever | <input type="checkbox"/> Neuritis, Neuralgia, Sciatica | <input type="checkbox"/> Reproductive Organ Ailment |
| <input type="checkbox"/> Cancer, Tumors | <input type="checkbox"/> Gout, Rheumatism | <input type="checkbox"/> Urinary Tract infection |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Bladder Disease |
| <input type="checkbox"/> Appendicitis, Diseased Bowel | <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other (specify)_____ | |

2. Name & address of health insurance company?_____

Group and/or Individual Policy number?_____

3. Will you be taking medication(s) on tour? Yes No

For what reason?_____

4. Do you have any physical or mental condition which may restrict your ability to participate in this travel group? Yes No

If yes, describe condition: _____

5. Do you have any chronic ailment, disease or other condition, now existing, which may lead to hospitalization, surgery or require special medical attention while traveling? Yes No

If yes, please describe: _____

6. Due to your medical condition, what special accommodations do you need to participate?
