MOUNT VERNON NAZARENE UNIVERSITY

Medical Release/History Long-Form for Off-Campus Travel

Complete this form – scan the form – submit the form electronically to the trip organizer/leader.

Participant's Personal Information

Name (print) _____

Male or Female (circle one) Date of Birth _____ Social Security # _____

Current Address _____ Primary Phone # _____

Primary Medical Insurance & Policy # _____ Phone # _____

Secondary Medical Insurance & Policy # _____ Phone # _____

Name of Parent, Guardian, or Spouse _____ Primary Phone # _____

Current Address _____ Work Phone # _____

Medical Emergency Contact

Name (print) _____ Primary Phone # _____

Relationship: ____ Parent ____Guardian ____ Spouse ____ Brother ____ Sister ____ Other (list) _____

Participant's Medical History

Answer each item – place in "X" in the appropriate box

	Yes	No		Yes	No		Yes	No
Asthma			Shortness of breath			Swollen/painful joints		
Epilepsy			Convulsions			Migraine headaches		
Diabetes			Mononucleosis			Menstrual disorders		
Heart trouble			Wear corrective lenses			Muscle/bone/joint disease		
Kidney trouble			Stomach/intestinal disorder			Nervous/mental disorder		
Thyroid condition			Loss of limb or digit			Dizziness/fainting spells		
Motion sickness			High/low blood pressure					

If you answered "yes" to any of the above, or if you have other medical conditions, provide details: _____

Describe allergies to any serum/medication, including the type of serum/medication and the nature of your reaction: _____

Describe any food allergies, including the type of food and the nature of your reaction: _____

If you regularly take any over-the-counter or prescription medication, provide the name/dosage/frequency of use: _____

Describe any psychiatric or psychological problems (e.g., anorexia, bulimia, claustrophobia, depression, panic attacks, phobias, suicide attempts, etc.) or any other medical condition. Include dates and treatments: _____

Height: _____ Weight: _____ Describe the type/nature/frequency of your physical exercise routine: _____

Date of last tetanus booster: _____ Date of last hepatitis A immunization or booster _____

Have you taken the series of 3 hepatitis B vaccinations? _____Yes _____ No (If yes, give dates): _____

Additional Health Needs

State whether you will need any of the following. Provide details for anything marked "yes."

- To take allergy shots? ____ Yes ____ No (details: _____)
- To be seen by a physician regularly? ____ Yes ____ No (details: _____)
- To be helped with physical mobility? ____ Yes ____ No (details: _____)
- Psychiatric consultation or therapy? ____ Yes ____ No (details: _____)
- Follow-up care for any existing injuries or illnesses? ____ Yes ____ No (details: _____)

Statement of Affirmation and Consent

- I affirm that the information provided on this form is accurate and complete – if any information is inaccurate or incomplete, I release MVNU from any liability and may be subject to disciplinary action by MVNU.
- The information on this form may be used by MVNU in an emergency situation – this form will remain on file and may be used for future trips, unless I notify the trip organizer/leader otherwise – it is my responsibility to update this form.
- I will submit a copy of my health insurance card with this form.

Participant Signature _____ Date _____

Legal Guardian Signature (if applicable) _____ Date _____

Permission to Secure Medical Treatment (to be signed in the presence of a Notary Public)

*This section is **required** for (a) all non-domestic trips and (b) domestic trips that exceed 7 days – this section is **optional** for all other trips.*

In the event that I am not able to make a medical treatment decision due to injury or illness, I, the participant, give permission to the below-named individual(s) to secure such treatment for me. In the case of a legal dependent, I, the legal guardian, give this same permission. Permissions extend from this date _____ until this date _____.

Participant Signature _____ Date _____

Legal Guardian Signature (if applicable) _____ Date _____

Individual's name (print) _____ Primary Phone # _____

Individual's name (print) _____ Primary Phone # _____

Individual's name (print) _____ Primary Phone # _____

To be completed by the Notary Public

State: _____ County: _____

Sworn to before me and subscribed in my presence this _____ day of _____, 20_____.

_____ _____

Notary Public Expiration Date