Himalayan Health
E X C H A N G E

MEDICAL HISTORY QUESTIONNAIRE

Mandatory for all applicants:

Trip Name: _____

Personal Information

Applicant Name: _____

Age _____Height _____Weight_____ Blood Type _____

1) Do you have any allergies (Including medications, latex, insects, environmental)? If you don't have any, please write "N/A".

2) Are you taking any medications? Please list (include prn meds).

3) Have you had any health problems or medical tests in the past.

4) Please list any recent injuries or illnesses.

5) Have you ever been treated or are you currently being treated for any emotional or psychological problems? (Please bear in mind that such illnesses are easily intensified under the additional stresses of studying, working, travelling or trekking abroad especially in an environment and terrain such as the Himalayas)

Physician Information

Name of Your Physician: _____

Day Phone: _____Evening Phone:_____

Contd. on Page 2…….

Disclaimer

I hereby authorize HHE to share the information listed in this form with HHE's partner institution abroad in order to provide adequate accommodations and urgent care in case of an emergency. I hereby understand that if a medical emergency occurs while in route to or from the destination location, or while participating in the HHE's field expedition, where I am unconscious or incoherent, HHE may contact my emergency contact listed on my application. If my emergency cannot readily be reached, I authorize HHE to select any medical provider to secure and administer medical treatment, including hospitalization and surgery, if needed. I hereby understand that any medical expenses incurred while abroad will are solely my responsibility. I hereby release Himalayan Health Exchange, its faculty and staff, the Georgia Board of Regents and the State of Georgia, from any liability in case of an accident and/or injury, including resulting in death. I hereby agree that I answered truthfully to the questions in this form and that omitting any information may result in a delay of medical care during an emergency, mistreatment of injury or illness, and/or administration of medications that may be hazardous to my health.

Signature _____

Name: _____ Date _____

_____

Parent/Legal Guardian's name and Signature (If participant is under 21 years of age)

Date: _____