HARVARD FIRST-YEAR OUTDOOR PROGRAM 2019
LEADER MEDICAL FORM, CONSENT REQUEST, AND LIABILITY WAIVER

PART I. To be completed by Participant

First Name _____ Last Name_____Gender (optional) _____

Birthdate_____

Name of First Emergency Contact_____
Relationship _____Mobile Telephone _____
Home Telephone _____Work Telephone _____
Email Address(es) _____
Home Address _____
(Street) (City) (State) (Zip)

Name of Second Emergency Contact_____
Relationship _____Mobile Telephone _____
Home Telephone _____Work Telephone _____
Email Address(es) _____
Home Address _____
(Street) (City) (State) (Zip)

Participant's Physician _____ Telephone_____

Medical Insurance Information – You must carry valid and current medical insurance and bring with you a valid insurance identity card to participate in FOP Leader Training and FOP Trips.

Insurance Company _____ Subscriber _____

Policy # _____ Group # _____
Are you participating in Harvard's Blue Cross/Blue Shield plan? ☐ **YES** ☐ **NO**

Prescription Drug Information Name on Card: _____

Prescription Bin #:_____ Company: _____

Prescription Group: _____ ID #: _____

***PLEASE ATTACH OF COPY OF YOUR MEDICAL INSURANCE CARD TO THIS FORM.**

CURRENT EXERCISE ACTIVITY- FOP Trips may involve significant exertion and generally require physical stamina. Do you exercise regularly? ☐ **YES** ☐ **NO** If Yes, list below:

Activity	**Times/Week**	**Approximate Time/Distance**	**Level of Intensity** (1- Easy, 5- Strenuous)
			1 2 3 4 5
			1 2 3 4 5
			1 2 3 4 5

MEDICAL CIRCUMSTANCES- Please note that FOP leaders and participants must be cleared for participation, which requires the completion of this form by a licensed health care provider as set forth below. FOP reserves the right to withhold medical clearance in the case of a missing medical form, an incomplete medical form or one with insufficient information, or as a result of certain medical conditions.

ASSUMPTION OF RISK AND GENERAL RELEASE

I have chosen voluntarily to participate in the HARVARD FIRST-YEAR OUTDOOR PROGRAM (the "Program"). ("Program" is understood to include all activities at destinations, and all travel to and from such destinations.) This agreement confirms my understanding of the following:

I understand that participation in the Program may involve risks inherent in traveling to, from, and within the Program destinations, as well as risks generated by the activities in which I engage while on the Program. I recognize that these potential risks include, for example, illnesses, injuries and even death. In particular, I recognize the unusual risks inherent in wilderness travel, including, for

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example, the potential difficulties and delays in obtaining medical aid when group participants are many miles from the nearest road or source of assistance, as well as the risks presented by out travel involving, mountains, rivers, and lakes. These include, without limitation, the risk of sustaining injuries or death from falling, drowning, lightning, avalanches and rock-fall, severe allergic reactions, insect bites and stings, and harsh weather conditions. I have made my own investigation of these risks, understand these risks and assume them knowingly and willingly. I understand that, although President and Fellows of Harvard College ("Harvard") has organized the Program, it cannot eliminate all risks or guarantee my safety while I am participating in the Program. I have made the independent judgment to participate in the Program and will take every precaution to safeguard my health during my participation.

I understand that it is my responsibility to alert Harvard if I have any allergies or other medical condition that may affect my participation in the Program. I authorize Harvard to obtain appropriate health care for me in the event that I need it but am unable to obtain it for myself. I further agree to hold harmless and indemnify Harvard for any and all actions taken by Harvard to provide necessary emergency medical care to me during the Program. I also understand and agree that if I experience serious health problems, suffer an injury, or am otherwise in a situation that raises significant health and safety concerns, then Harvard may contact my parents or any other person whose name I have provided as my "emergency contact."

I agree to abide by all policies Harvard has put in place for the Program and to respect the authority of Program leaders and other Program officials at all times. I understand that violation of any such policies is grounds for my removal from the Program, and that I then would bear any additional travel or other expenses incurred as a result. In particular, I understand that possession or use of alcohol, firearms, fireworks, non-prescription drugs, and tobacco is prohibited during the Program. Other proscribed behavior includes diving, playing pranks, unauthorized rock-climbing, solo hiking or swimming, and any other activity Harvard Program leaders deem unwise or unsafe. I accept responsibility for my own behavior, and promise to act safely and responsibly at all times.

I understand that Harvard does not represent or act as an agent for, and cannot control the acts or omissions of, any transportation carrier, hotel, tour organizer or other provider of food, goods or services involved in the Program. I understand that Harvard is not responsible for matters that are beyond its control, and that it cannot warrant the safety or convenience of the circumstances under which I will be traveling or otherwise participating in the Program.

Knowing the risks described above, I agree, on behalf of my family, heirs and personal representative(s), to assume all the risks and responsibilities surrounding my participation in the Program. To the maximum extent permitted by law, I release, hold harmless and agree to indemnify Harvard, and its officers, directors, faculty, staff, representatives, employees and agents, from and against any present or future claim, loss or liability for injury to person or property which I may suffer, or for which I may be liable to any other person, related to my participation in the Program (including periods in transit to or from my destination), resulting from any cause, including but not limited to ordinary or gross negligence.

I certify that I am age 18 or older. I have carefully read and freely signed this Assumption of Risk and General Release. I understand and agree that no oral or written representations can or will alter the contents of this document. I agree that this agreement shall be governed by the laws of the Commonwealth of Massachusetts (excluding its conflict of laws principles), which shall be the forum for any lawsuits filed under or incident to this agreement or the Program.

Signature of Participant _____ Date: _____

If the participant is under age 18, the parent and/or legal guardian must sign below:

I, the undersigned parent and/or legal guardian of the participant listed above (the "Participant"), do hereby consent to his or her participation in the Program. I, as the parent of the Participant and on behalf of the Participant, release, hold harmless and agree to indemnify Harvard, and its officers, directors, faculty, staff, representatives, employees and agents, from and against any present or future claim, loss or liability for injury to person or property which I or the Participant may suffer, or for which the Participant may be liable to any other person, related to the Participant's participation in the Program (including periods in transit to or from the Participant's destination), resulting from any cause, including but not limited to ordinary or gross negligence.

Signature of Parent/Guardian _____ Date: _____

Printed Name _____

First Name _____ Last Name_____ Birthdate_____

Part II . To Be Completed by Physician or Nurse Practitioner

THIS ENTIRE MEDICAL FORM MUST BE FULLY COMPLETED BY A LICENSED HEALTH PROVIDER BEFORE PARTICIPANT MAY BE CLEARED TO PARTICIPATE IN FOP PROGRAMS. **PURSUANT TO AMA CODE OF ETHICS E-8.19, HEALTH PROVIDER MAY NOT BE AN IMMEDIATE FAMILY MEMBER.** THE INFORMATION ON THIS FORM WILL USED TO DETERMINE WHETHER THERE ARE ANY MEDICAL ISSUES THAT MIGHT PRECLUDE OR LIMIT THE INDIVIDUAL'S ABILITY TO SAFELY PARTICIPATE IN FOP.

TO THE EXAMINING PHYSICIAN OR NURSE PRACTITIONER

* Physical examinations should include, without limitation: height, weight, BMI, blood pressure, resting pulse, general appearance (look for stigmata of Marfan's), heart (in particular, auscultation standing, supine; +/- femoral artery bruits), pulses (simultaneous femoral and radial pulses), lymph nodes, lungs, abdomen, skin (particularly for lesions suggestive of MRSA, tinea corporis), neurology, musculoskeletal system (neck, back, shoulder/arm, wrist/hand/fingers, hip/thigh, knee, leg/ankle, foot/toes).
*Participants in the Harvard First-Year Outdoor Program (FOP) will be traveling under their own power, often carrying loads of approximately 40-70 pounds, up and down steep mountain trails, six to ten miles a day for five days.
*FOP operates in remote areas where evacuation to modern medical facilities can take several days.
*Weather conditions can be unpredictable and extreme. Prolonged storms, high winds, intense sunlight, and sudden immersion in cold water are possible.
*On the basis of your knowledge of the individual's medical history and this examination, do you advise any limitations on participation in strenuous physical activities such as backpacking or canoeing? In your opinion, is there is anything in his or her medical background that would preclude or limit participation in FOP?
*Does this patient have any cardiac conditions? As background, the American Heart Association recommendations on pre-participation examination of athletes is included here: Maron, B.T., et al., *Circulation*, *94*: 850-6.
*Please be as specific as possible in explaining any such medical issues and the limitations they might require.
*PLEASE WRITE LEGIBLY. We will have to follow up on any notes or comments we cannot decipher.

HEIGHT_____WEIGHT_____ BMI_____BP_____

GENERAL MEDICAL HISTORY-

Does the student currently have or does he/she have a history of any of the following? Each question must be answered.

1. Respiratory problems? Asthma?	☐YES ☐NO	12. Neurological problems? Epilepsy?	☐YES ☐NO
2. Bleeding or blood disorders?	☐YES ☐NO	13. History of visual or hearing deficits? (other than glasses or contact lens use)	☐YES ☐NO
3. Hepatitis or other liver disease?	☐YES ☐NO	14. Fatigue?	☐YES ☐NO
4. Cardiac problems?	☐YES ☐NO	15. Diabetes?	☐YES ☐NO
5. Heart murmurs?	☐YES ☐NO	16. Has student ever not passed a medical clearance for any activity or event in the past?	☐YES ☐NO
6. Dizziness or nonvasovagal fainting episodes with exertion?	☐YES ☐NO	17. Gastrointestinal disturbances?	☐YES ☐NO
7. Unexplained excessive fatigue with exertion?	☐YES ☐NO	18. History of frostbite or Raynaud's Syndrome	☐YES ☐NO
8. High blood pressure?	☐YES ☐NO	19. History of heat stroke or other heat-related illness?	☐YES ☐NO
9. Chest pain with exertion?	☐YES ☐NO	20. History of serious reaction to high or low temperatures?	☐YES ☐NO
10. Family history of premature sudden cardiac death and/or heart disease in relatives under the age of 50?	☐YES ☐NO	21. Any other serious illness?	☐YES ☐NO
11. Clinically significant arrhythmias? Marfan's?	☐YES ☐NO	22. Concerns with eating habits, body image, restrictive eating and/or been diagnosed with an eating disorder (e.g., anorexia, bulimia, etc.)	☐YES ☐NO
23. Is the student currently, or has the student ever been, under the care of a mental health specialist for a condition that might preclude safe participation (for example, panic attacks, severe anxiety disorder or severe phobias such as fear of heights or fear of insects)?			☐YES ☐NO

Examiner's detailed comments- (All "yes" answers must be elaborated on. If necessary attach a separate page to this medical form.)

Item #	Comments

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MUSCULAR/SKELETAL INJURIES-

Many muscular/skeletal injuries may reoccur when a student is under the physical stress of a backpacking trip. Please indicate **ANY** past histories with the following conditions:

24. Knee, hip or ankle injuries (including sprains) and/or operations?	☐YES ☐NO
25. Shoulder, arm or back injuries (including sprains) and/or operations?	☐YES ☐NO
26. Head injury?	☐YES ☐NO
27. Any other joint problems?	☐YES ☐NO
28. Frequent muscle cramps?	☐YES ☐NO

Examiner's detailed comments- (include date of last occurrence and the effect of the problem on current activity level):

Item #	Comments

ALLERGIES/DIETARY RESTRICTIONS-

Does the student have a history of allergies to any of the following? Write in any others not listed:

29. Iodine?	☐YES ☐NO	33. Insect bites or bee stings?	☐YES ☐NO
30. Peanuts?	☐YES ☐NO	34. Other_____	☐YES ☐NO
31. Other foods?_____	☐YES ☐NO	35. Other_____	☐YES ☐NO
32. Medications?_____	☐YES ☐NO	36. Other_____	☐YES ☐NO

Examiner's detailed comments- (All "yes" answers must be elaborated on. If necessary attach a separate page to this medical form.)

Item #	Reaction	Medication/Treatment Required

CURRENT MEDICATIONS-

Is he/she currently taking any medications? Include whether they will need to take this medication during the trip.

Medication	Dosage (amt./freq)	Condition	Side Effects/Restrictions	Bring on trip?
			☐NONE ☐_____	☐YES ☐NO
			☐NONE ☐_____	☐YES ☐NO
			☐NONE ☐_____	☐YES ☐NO
			☐NONE ☐_____	☐YES ☐NO

ANY OTHER MEDICAL CONDITION WITH POTENTIAL EFFECTS ON STUDENT'S PARTICIPATION?

_____

_____

_____

_____

If there is any pertinent medical information you believe is necessary to illustrate or explain specific comments above (i.e., laboratory results, MRI/X-ray results, cardiac test results), you may feel free to attach copies to this form.

Signature of physician or nurse practitioner _____ Date _____

Physician Name _____ Telephone _____

Address _____
(Street) (City) (State) (Zip)

TO THE FOP Leader:

Please be sure that this form is FULLY and accurately completed and mailed to 6 Prescott St, Cambridge, MA 02138 or dropped off at the FOP Office in Matthews basement (use the secure drop box)

Don't forget to attach a copy of your insurance card(s)!