

Medical Disclosure and Emergency Contact

The information provided in this form is confidential and will only be consulted by the medical/Toolik staff in case of an emergency.

Please complete the form and bring it back to the Manager’s office within 48 hours of arrival.

LAST NAME _____ **FIRST NAME** _____
PREFERRED FIRST NAME _____ **PRONOUNS** (optional) _____
DATE OF BIRTH _____ **BLOOD TYPE** _____
SEX ASSIGNED AT BIRTH (please circle one) male female intersex
GENDER (please circle) man woman other _____
MEDICAL TRAINING: Please check the box if applicable

- Basic First Aid
- CPR
- Advanced/ETT/WFR
- EMT. Specify level (I, II, III) and State certified _____

Are you willing to be posted as a currently certified EMT and available in the case of emergency?

Yes
 No

The following medical information may be necessary in the event of serious illness or accident. Please complete this form accurately and truthfully. This form is for your protection - the more complete the form, the better the medical treatment you may receive, if needed. *Failure to disclose accurate and complete information could compound the seriousness of an accident or illness*, particularly if you are unable to clearly answer the medical responders’ inquiries. Please return additional pages if more space is needed.

IMPORTANT: If you know or suspect that you have some medical situation that may be aggravated by intense field work, and the situation is not covered in any of the questions in this form, you **MUST** explain it, at the end of this form. Also, if you discover at any point before or during your stay at the station that you need to amend this form (e.g., discover you have the hepatitis-B virus), you **MUST** inform the EMT with the change as soon as reasonably possible.

PERSON TO CONTACT IN EVENT OF EMERGENCY (parents or nearest relative)

Name:	Relationship:
Phone:	Alternate phone:
E-mail:	Additional contact info:
Address:	

If the person named above is not available in the event of an emergency, notify:

Name:	Relationship:
Phone:	Alternate phone:
E-mail:	Additional contact info:
Address:	

HEALTH & MEDEVAC INSURANCE: Toolik Field Station strongly recommends medical and medical evacuation insurance that will cover the expenses of serious illness or accident. Project members are responsible for all expenses in the event that they become ill, injured, or require emergency evacuation. **NOTE:** You are 375 miles from the nearest hospital, located in Fairbanks, AK. Options for evacuation: 1) Drive to Fairbanks, 9+ hours, 2) Charter air ambulance from Galbraith strip, nine miles south of Toolik, 3 hours to get plane to Galbraith, 2 hours to fly to Fairbanks or Anchorage. Cost can range upwards of \$75,000 for air ambulance (weather dependent). 3) Drive to Prudhoe Bay Clinic, 133 miles or 4 hours. **TFS will call the medevac company that you list below in the event of an emergency; if you are mentally incapacitated at the time of injury and no preference is listed, the decision will be made for you. If, for any reason, your first choice is unavailable, another agency will be requested should you be incapable of making rational medical decisions at the time of the incident.**

Health insurance company _____
 Policy# _____ Phone Number _____

Do you have medevac insurance? **Yes** **No**

Medevac company preference _____
 Membership# (if any) _____

HEALTH HISTORY: Please check if applicable. If yes, please specify the time frame of health history in the lines below (for example, 2010 — mononucleosis).

- | | | |
|---------------------------------------------|----------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hyperglycemia |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Heart disorders | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> HIV positive |

Explain any check above and any situation is not listed (for example, mononucleosis in 2010)

Do you currently possess a valid Do-Not-Resuscitate order (DNR) or advance directive? If yes, please provide a copy to the EMT.

Yes **No**

GENERAL ALLERGIES: Please check if applicable and specify symptoms (for example, peanuts – hives).

- Insect bites or stings
- Animal hair/dander
- Pollen (hay fever)
- Foods* – Specify _____
- Other – Specify _____

****Please discuss any food allergies with the kitchen staff if you have not provided the details of your allergies/dietary restrictions in your myToolik profile.***

MEDICINAL ALLERGIES: Please check if appropriate and specify symptoms (for example, penicillin – hives).

- | | |
|--------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Tranquilizers - Librium, Valium, etc, |
| <input type="checkbox"/> Pain meds - Codeine, Morphine, etc. | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Ampicillin | <input type="checkbox"/> X-ray dyes |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Erythromycin or other "mycins" |
| <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Sleeping pills |
| <input type="checkbox"/> Novocain or other local anesthetic | <input type="checkbox"/> Vaccine sera |
| <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Others - Specify |

Explain any of the checks above (general and medicinal allergies) and detail any symptoms you typically have _____

PHYSICAL CONDITION: Please list all physical disabilities, chronic illnesses, previous injuries or any other limitations that could affect your full participation during your stay at the station.

Can you swim? (yes/no) _____

Do you have/wear:

- | | |
|----------------------------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Artificial limb/prosthesis. If so, specify _____ |
| <input type="checkbox"/> Glasses _____ | |
| <input type="checkbox"/> Hard contact lenses | |
| <input type="checkbox"/> Soft contact lenses | |

DIETARY RESTRICTIONS: Are you on a restricted diet for any medical reason? Please describe any dietary restrictions and make sure you have properly filled out details in MyToolik profile

MEDICATIONS: TFS cannot provide you with prescription medications. Bring sufficient quantities of required medications and the prescription should you need an additional amount. List all medications you will be taking during your stay. Are you taking any medication(s) for which it would be critical or life-threatening if you run out? All medicines, prescribed or over-the-counter, must be transported in their original packaging.

GENERAL: Is there ANYTHING in your medical history or present health status that has not been covered in this form, and which you think we should be aware of to help you participate in Toolik Field Station research projects? Are there any treatments you don't want performed for religious or other reasons?

HEALTH AND SAFETY CERTIFICATION - STATEMENT:

I have consulted with a medical doctor with regard to my personal medical needs. I am aware of all applicable personal medical needs. There are no health-related reasons or problems that preclude or restrict my participation in Toolik Field Station research programs.

The Toolik Field Station may, but is not obligated to, take any actions it considers to be warranted under the circumstances regarding my health and safety. I agree to pay all expenses relating thereto and release the Toolik Field Station, University of Alaska Fairbanks, from any liability for any actions.

In the event that I am physically incapable of consenting to medical attention, I place within the discretion of the designated station safety personnel, the decision to seek and allow professional medical attention or services.

I assume all risk and responsibility for my own medical needs. I hereby waive all claims or causes of action against the Toolik Field Station, University of Alaska Fairbanks, its auxiliary organizations, and the officers, directors, employees, and agents for responsibility for any health problems incurred during my participation in the above-referenced participation of research programs at the Toolik Field Station.

Participant's Signature	Printed Name	Date
_____	_____	_____
Parent/Guardian Signature (if under 18)	Printed Name	Date
_____	_____	_____