

Nickname/Name Gone By

## MEDICAL INFORMATION FORM- ADVENTURE RECREATION PROGRAMS

### I. PARTICIPANT INFORMATION (PLEASE PRINT)

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Local Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Local phone number where you can be reached: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Male \_\_\_\_ Female \_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Height \_\_\_\_ Weight \_\_\_\_ Smoker: YES NO

Emergency Contact: \_\_\_\_\_ Relation to Participant: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

### II. MEDICAL INFORMATION

Date of last Tetanus Booster \_\_\_\_/\_\_\_\_/\_\_\_\_

List any medication to which you are allergic: \_\_\_\_\_

List any other allergies (food, plants, bee stings): \_\_\_\_\_

Do you require and/or carry any medications for allergic reactions (circle one)? YES NO

If yes, please list **what you are carrying with you on the activity**: \_\_\_\_\_

*Adventure Recreation staff are trained to assist participants who are **PRESCRIBED** with epinephrine auto-injectors in the event of an allergic reaction that progresses to a life threatening stage. Adventure Recreation **DOES NOT** carry epinephrine auto-injectors or administer epinephrine to participants without prescriptions.*

Do you have any current and/or on-going illness or condition such as diabetes or high blood pressure? YES NO

If yes, please list: \_\_\_\_\_

Do you require and/or carry medication? YES NO

If yes, please indicate: \_\_\_\_\_

Please list any joint or orthopedic problems you have: \_\_\_\_\_

Please indicate any history of heart problems including hospitalization, and treatment dates: \_\_\_\_\_

### III. INSURANCE

Are you covered by any Hospitalization or Medical Care Policy? YES NO

If yes, name of insurance company issuing the policy: \_\_\_\_\_

Policy or certification number: \_\_\_\_\_

### IV. SIGNATURE (IF PARTICIPANT IS UNDER 18 YEARS OF AGE, PARENT OR GUARDIAN MUST SIGN)

I fully understand the rigorous nature of the program that I am participating in. In the event of an accident or emergency that renders me unable to communicate, I grant my permission for any medical care, operations, and/or anesthesia, which might become necessary.

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(Must be signed by parent or guardian if participant is under the age of 18 )