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)