

CONFIDENTIAL PERSONAL INFORMATION

I. PERSONAL INFORMATION:

1. **PROGRAM:** Text **DATES:** Text
2. **Your Name:**(printed) Text Male: Text Female: Text
3. **Address:** Text **City:** Text **State:** Text **Zip:** Text
4. **Phone#:** Home: Text Work: Text **E-mail:** Text
5. **DOB** and Age: Text Height: Text Weight: Text
6. Name of company and policy number of your medical and hospital insurance if possessed: Text
Text
7. **In case of emergency notify:** Name: Text
Relationship: Text **Address:** Text
Home **Phone:** Text Work: Text
8. Family physician: Text
Address: Text **Phone:** Text

II. MEDICAL HISTORY:

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING: Please type yes or no:

1. Dizzy spells, fainting, convulsions, persistent headaches? Text
2. Shortness of breath or chest pain? Text yes no
3. Heart, circulatory or blood pressure problems? Text yes no
4. Back or skeletal problems? Text Text yes no
5. Allergies? Please specify. Text yes no
6. Any phobias? Specify. Text yes no
7. On any medication? If so, what? Text yes no
8. **Any other medical problems that may be pertinent to your participation in this program's outdoor adventure activities?**
Text

9. If you answered "yes" to questions 1 - 4, please explain: Text
Text

I understand that I may, at my sole discretion, refrain from involvement in any activity which I deem inappropriate given my health status and, with respect to any activity in which I do participate, I hereby acknowledge and embrace personal responsibility for safety, including attentiveness to all possible risk at all times. (Note: *We do not carry medical insurance for participants.*)

Text

Today's Date
Text

Text

Participant's Signature
Text

Today's Date

Guardian's Signature