



Outdoor Adventure Medical Information Form

Please print legibly.

I. General Information

- 1. Name Today's Date
2. Address Street # City St Zip
3. Cell phone Work Phone
4. () Male () Female Height Weight DOB
5. Group or Organization

II. Emergency Contact Information

First / Last Name Relation
Cell Phone Work Phone

III. Medical History

1. Do you currently have or have had in the past 5 years any of the following symptoms or conditions?

- Yes No Asthma Yes No Back, Neck, Knee problems
Yes No Broken Bones Yes No Chest Pains, Palpitations, or Heart Murmur
Yes No Diabetes Yes No Pregnant (Just Current)
Yes No Epilepsy Yes No Heart Disease or Attack
Yes No High Blood Pressure Yes No Stroke

WE HIGHLY RECOMMEND THAT PARTICIPANTS WITH ASTHMA BRING INHALERS.

2. Check any of the following current allergies.

Poison Ivy Ants Pollen Bees Grass Specific Medication

If checked, explain allergic reaction for each allergy.

3. Are you currently taking prescription medication, or over-the-counter? YES NO

Name: How Often: Dosage:
Name: How Often: Dosage:

4. Check and date any of the following heat conditions you've experienced in the past 5 years.

Dehydration Date (include year) Were you hospitalized? YES NO
Heat exhaustion Date (include year) Were you hospitalized? YES NO
Blacked out Date (include year) Were you hospitalized? YES NO

IV. Signature

I am aware of my past and present health and fitness condition when engaging in strenuous activity. I fully understand the rigorous nature of the Challenge Course and I assume all responsibility, risk and liability pertaining to my physical condition.

Participant Printed Name Participant Signature Parent or Legal Guardian Signature Date
(If participant is under 18 years old)