

CONFIDENTIAL HEALTH FORM AND PARTICIPANT'S QUESTIONNAIRE

*Please fill out one per participant and return no later than
one week before the program.*

Name: _____ Age: _____ (if over 50 physician signature required for
all out-door climbing programs)

Phone # _____

Address _____

Whom to call in an emergency, and phone #: _____

Health Status: Check those which apply.

_____ Heart Condition

_____ High Blood Pressure

_____ Diabetes

_____ Shortness of Breath

_____ Chronic headaches

_____ Allergic reaction to bee stings

_____ Smoker

_____ Recent Surgery or Illness

_____ Arthritis

_____ Current Medication, specify _____

_____ Asthma

_____ Convulsions

_____ Special Diet, specify _____

_____ Attention / Hyperactivity Disorder

Height: _____

Weight: _____

Other limiting physical conditions or other special health considerations: _____

I do _____, do not _____ carry medical insurance with _____

Company and policy # (optional) _____

Your top three favorite hobbies: _____

Signature of program participant: _____ Date: _____

Signature of legal guardian if participant is under 18 years of age:

_____ Date: _____

Physician's Signature (if applicable)

_____ Date: _____

