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 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:_____