MEDICAL DISCLOSURE

PROGRAM/DATES: _____

PARTICIPANT: _____

The following medical information may be necessary in the event of serious illness or accident. Please complete this form accurately and truthfully. The facts you disclose will be kept confidential and will be used only to help the staff respond to an injury or illness. Failure to disclose accurate and complete information could compound the seriousness of an accident or illness, particularly if you are unable to respond clearly to the medical staff's inquiries. Please print your responses.

Have you experienced any of the following?:

__Hypo/Hyperthermia	__Heart Disease/ Stroke	__Asthma	__Back Condition	__Seizures
__Diabetes	__Allergy to Sulfa Drugs	__Ear Disease	__Balance Problems	__Head Injury
__Bee Sting Allergy	__Allergy to Penicillin	__Epilepsy	__Frostbite	__Other

If you checked any of the above, please explain more fully _____

_____

Any other pertinent information?: _____

_____

MEDICATIONS: List all medications you are taking or will be taking during this program. All medicines, prescribed or over-the-counter, must be transported in their original packaging.

_____

PERSON TO CONTACT IN EVENT OF EMERGENCY (parents or nearest relative)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Office Phone: _____ email: _____

Assumption of Risk

I have consulted with a medical doctor with regards to my personal medical needs. I am aware of all applicable personal medical needs. There are no health-related reasons or problems that preclude or restrict my participation in this program. I assume all risk and responsibility for my medical needs.

Signature of Participant: _____

Participant's Signature Printed Name Date

Signature of Parent or Guardian if participant is a minor: _____

Parent/Guardian's Signature Printed Name Date

_____

Parent/Guardian's Signature Printed Name Date