MADISON SCHOOL & COMMUNITY RECREATION

Elements Ropes Course & Team Building Program

HEALTH FORM

Participant Name_____ Birth Date_____

Group Name_____ Program Date _____

Home Address_____ Phone _____

City_____ State_____ Zip_____

Health Insurance Provider: _____ Hospital Preference: _____

Group #: _____ Subscriber #:_____ Doctor's Name: _____

In case of emergency, notify_____ Phone (1)_____

Their relationship to you?_____ Phone (2)_____

It is vital to the health and safety of program participants that all medical conditions or concerns be fully disclosed on this form. It is the responsibility of the program participant to assure that the following information is complete and accurate.

Medications being taken_____

Do you currently have any of the following medical conditions? (Check all applicable)

____Heart Condition ____Diabetes ____Asthma ____Allergies ____Pregnancy ____Other

If yes, participation in the program may be limited/altered/modified.

Please briefly explain any condition that you checked (for pregnancy, provide due date:
_____
_____

Orthopedic problems (including recent sprains or breaks):
_____
_____

Please describe any other health condition(s) or use of prostheses or medical devices (i.e. hearing aids, etc.) that might affect your participation in any physical activity:
_____
_____

In the event I cannot be reached in an emergency, I grant permission to MSCR to secure and administer treatment by approved physician(s) and/or health care provider(s) for necessary medical, surgical, dental or health care during the MSCR experience.

I also understand that my signature on this form denotes permission to disclose pertinent health information to appropriate MSCR personnel or other entities designated as having a legitimate health interest.

Signature_____ Date_____
(if under 18 years of age—must be signed by parent or guardian)