

**MEDICAL INFORMATION/INFORMED CONSENT**

Name \_\_\_\_\_  
First Middle initial Last

Telephone (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Home Work

Personal physician \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
Name

In case of emergency, please contact \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Special dietary considerations: \_\_\_\_\_

List known allergies: \_\_\_\_\_

List required medications: \_\_\_\_\_

If you are allergic to bee stings, do you have a bee sting kit? \_\_\_\_\_

Do you wear contact lenses? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

Have you had or do you now have (circle if yes): Heart attack Diabetes Asthma  
Angina Epilepsy Chest pains Drug reactions High blood pressure Heart murmur

If you answered "yes" to any of the above, explain and include a date: \_\_\_\_\_

Do you have any other medical conditions that we should be aware of? \_\_\_\_\_

I am not under the influence of any chemical substance, including alcohol. Understanding that any physical activity involves a risk of injury, I understand that my participation in the \_\_\_\_\_ (Name any council) climbing/rappelling program is entirely voluntary. I release \_\_\_\_\_ (Name any council), its employees, and staff from any claims or liability arising out of my participation. This release does not, however, apply to any harm caused by negligence or willful misconduct of \_\_\_\_\_ (Name any council) or its employees.

**Please print clearly.**

Name \_\_\_\_\_

Course/company \_\_\_\_\_

Participant's signature\* \_\_\_\_\_ Date \_\_\_\_\_

\*If the participant is under age 18, a parent or guardian must also sign below:

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_