

Renaissance Adventure Guides, LLC
Confidential Participant Health Information
ALL PARTICIPANTS MUST FILL OUT

Renaissance Adventure Guides, LLC provides recreational opportunities for youth/adults to hike, camp, kayak and/or participate on a challenge course. This program can involve strenuous physical activity and may place you/ your child in physically, emotionally and mentally stressful situations. It is important that all participants be in generally good physical condition. Due to the level of physical exertion involved, anyone with health concerns should not participate. Consult with your physician before participating in any physical program.

Please complete all of the following information:

Name _____ Organization _____

Height _____ Weight _____ Age _____ Date of Birth _____ Sex M or F

Street address _____ City _____ State _____ Zip _____

Home phone # _____ Work phone # _____

Parent/Guardian name (please print) _____

Other Emergency Contact name _____ phone # _____

Do you/your child have medical coverage? YES or NO

If yes name of Company _____ & Policy number _____

Doctor Name and Number _____

I, the undersigned parent or guardian of the above named participant do hereby give my consent, in the event all reasonable attempts by authorized medical personnel to contact me at the phone numbers listed above have been unsuccessful, for

- * 1. Administration of pre-professional care to the level of training of the recreation program's employee
- * 2. The administration of any treatment deemed necessary by a licensed physician.
- * 3. To transfer the participant to a hospital that is reasonably accessible.
- * 4. I agree that I am solely responsible for payment of all costs resulting from medical and ambulance services.

This authorization does not cover major surgery unless the medical opinion of a second licensed physician concurring in the necessity for such surgery is obtained prior to the performance of such surgery.

The following information is provided to assist personnel to administer medical attention to me and/or my child or ward.

Does participant have (or had) any of the following conditions? Circle Yes or No to each, explain as needed

YES	NO	fainting	YES	NO	earache/ear infection(s)
YES	NO	asthma/respiratory problems	YES	NO	heart problems
YES	NO	diabetes	YES	NO	seizures
YES	NO	stomachaches	YES	NO	major illness this past year
YES	NO	operations/surgery	YES	NO	psychological problems
YES	NO	last tetanus shot _____	YES	NO	food allergies _____
YES	NO	previous injuries (back/head/broken bones)	YES	NO	other allergies? (Bee stings, medication)
YES	NO	Has a doctor instructed you to limit your activity in any way?			
YES	NO	Are you or your child taking any medications?			

List Medications (amount and how often) _____

BRING ANY MEDS THAT MAY BE NEEDED (Staff is not permitted to dispense any medications)

PLEASE explain any of the above _____

Signature of parent/legal guardian _____ **Date** _____