Medical Information
Use for non-Scout participants.

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 _____