Ascend Outdoor Adventures
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Medical Form

PARTICIPANT NAME____AGE______
Address____ Male Female
City____State________Zip__________
IN CASE OF EMERGENCY, CALL:
NAME_____________________________________ Relationship__________________
Day Phone ______________________ Night Phone ______________________
Cellular Phone ______________________
Doctor's Name_____________________________ Doctor's Phone__________________
Insurance Co.______________________________
Insurance ID#___________________

We/I give our/my consent to Ascend Outdoor Adventures to authorize emergency examinations and/or diagnostic procedures, procurement of medical treatment, emergency surgery and the administration of necessary anesthetics, when in the opinion of any physician or surgeon of good standing such medical treatment is necessary for the mental or physical health of the participant and we/I cannot be reached within a reasonable time to obtain our consent to treatment. We/I either have appropriate insurance or, in its absence, agree to pay all the costs of rescue and/or medical services as may be incurred on my/our behalf.

Participant Signature______________________________ Date_________

IF THE PARTICIPANT IS UNDER 18 YEARS OF AGE,
A PARENT OR LEGAL GUARDIAN MUST SIGN BELOW.
Parent Signature________________________________ Date__________

Medical History:

Have you had, or do you currently have: (Circle Yes or No)

1. Heart Problems YES NO
2. Allergies (Bees, Drugs, etc.) YES NO
3. Low or high blood pressure YES NO
4. Dizziness, recurrent headaches, fainting YES NO
5. Diabetes YES NO
6. Lung problems or asthma (carry inhaler?) YES NO
7. Back problems YES NO
8. Any known phobias YES NO
9. Any known diseases or illness. YES NO
10. Drugs or medications being taken YES NO
11. Severe abdominal or menstrual pain YES NO
12. Emotional impairment or disability YES NO
13. Epilepsy or convulsions YES NO
14. Recent sprains, fractures, or dislocations YES NO

*Are you currently pregnant? YES NO
Blood Type ______________ Date of last Physical Exam ______________
DO YOU KNOW OF ANY HEALTH PROBLEMS OR CONDITIONS YOU HAVE THAT WOULD PREVENT YOU FROM PARTICIPATING IN OUR PROGRAMS? YES NO
Immunizations:
Tetanus YES NO UNKNOWN Date:_________ **Hepatitis A** YES NO UNKNOWN Date:_________
MMR YES NO UNKNOWN Date:_________ **Hepatitis B** YES NO UNKNOWN