

HEALTH FORM

Challenge Adventures

To help us provide assistance to you in case of an emergency, we ask you to complete this form and return it to us at least three week prior to your adventure. All information will be held in confidence and will be released only to the appropriate individuals. If you need additional room, please continue on the back page.

Participant's Name _____

Adventure Dates _____

Your Height _____ Your Weight _____ Your Age _____

Yes No

Are you allergic to any foods? If yes, please list: _____

Do you require a special diet? If yes, please describe: _____

Do you have allergies to drugs or insect stings/bites? If yes, please describe: _____

Are you subject to epileptic or other seizures? If yes, please describe: _____

Do you have heart, respiratory or other health impairments? If yes, please describe: _____

Are you taking any medications? If yes, please list: _____

Note: If taking medications, please be sure to bring an adequate supply with you in the original container.

Please describe any health problems, recent surgery or health conditions we should know about:

In the Event of an Emergency, the Person to Contact Is:

Name: _____ Relationship: _____

Address: _____

Phone (Home): _____ (Work): _____

Name of Physician: _____ Phone: _____

Physician's Address: _____

Health Insurance Company: _____ Policy #: _____

To Be Completed by Parent or Guardian of Participants under 16 Years of Age:

*I authorize Challenge Adventures or its agents to obtain medical care for my child (name):
_____ in case of any emergency. I also authorize the
administration of prescription drugs provided by me with instructions on their use.*

Parent or guardian signature

Date

Additional Comments:
