

JACK ROBERTS CLIMBING ADVENTURES
Participant Health Statement & Authorization for Medical Treatment

Name: _____ Date: ____/____/____

Program Participating In: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (H) _____ (W) _____ (C) _____

*Please complete the following as thoroughly as possible. The information will be used by only trip leaders in the program and any emergency personnel. All material is confidential.

HEALTH INSURANCE CO. & POLICY NUMBER: _____

Do you have any physical disabilities or conditions : YES/ NO
(Heart conditions, diabetes, seizures, etc) that may/will affect your participation?

Please include any allergies (bees, food etc):

If YES: please list disabilities or conditions:

Are all your immunizations current (tetanus, booster, etc....) YES/ NO

Name of Family physician _____ Phone: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Address: _____

CITY: _____ STATE: _____ ZIP: _____

In the event that I am rendered unable to communicate due to illness, accident, or emergency while participating, I hereby give permission to the Physician, selected by the program personnel to hospitalize, secure proper treatment for, and to take whatever medical actions necessary to treat me.

Participant Signature _____ Date

Full Name (Printed)

Parent/Guardian Signature if under 18 years of age _____ Date