

CWS MEDICAL HISTORY FORM

(TO BE FILLED OUT ANNUALLY BY ALL PARTICIPANTS)

TO BE FILLED OUT BY PARENT, GUARDIAN, OR ADULT PARTICIPANT. PLEASE PRINT IN INK.



Height _____ Weight _____ Eye color _____ Hair color _____

PRINTED NAME: _____ Today's Date: _____

Primary Phone (____) _____ - _____ Home Work Cellular

Address _____ City _____ State/ Zip _____

EMERGENCY CONTACT

Name _____ Relation _____

Phone (____) _____ - _____ Home Work Cellular

AS A PARTICIPANT / PARENT OR GUARDIAN I UNDERSTAND THAT:

The Center for Wilderness Safety (CWS) does not make a determination of a participant's fitness for an event; rather, the participant represents to CWS and verifies that they are physically fit and ready for an event. It is important to discuss all medical conditions and/ or physical activity concerns with a CWS staff member prior to participation in all activities. All information given will be held in strict confidence.

I understand and acknowledge that my failure to disclose relevant information may result in harm to myself/ my child and/ or others during an event. I represent and warrant that I have provided all materials and important information to the Center for Wilderness Safety pertaining to my medical, mental and physical condition related to my participation. I agree to notify the Center for Wilderness Safety of any changes in my mental, physical or medical condition prior to my scheduled event.

Medications (prescribed or over the counter) arriving with minors under the age of 18 must be in original pharmacy labeled containers. These medications may only be in amounts sufficient for the duration of stay at the course.

Please check either **yes** or **no** for the following questions. Do you (the participant) have currently have or have a history of:

- | | | | | | |
|---------------------------|--------------------------|----------------------------------|---------------------------|--------------------------|--|
| <input type="radio"/> Yes | <input type="radio"/> No | Diabetes or Blood Sugar Problems | <input type="radio"/> Yes | <input type="radio"/> No | ADD or ADHD |
| <input type="radio"/> Yes | <input type="radio"/> No | Asthma or Respiratory Problems | <input type="radio"/> Yes | <input type="radio"/> No | Are you pregnant? |
| <input type="radio"/> Yes | <input type="radio"/> No | Epilepsy or Seizures | <input type="radio"/> Yes | <input type="radio"/> No | Musculoskeletal Injuries |
| <input type="radio"/> Yes | <input type="radio"/> No | Heart Disease | <input type="radio"/> Yes | <input type="radio"/> No | Orthopedic conditions that are aggravated by physical activity |
| <input type="radio"/> Yes | <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes | <input type="radio"/> No | Bleeding Disorders |
| <input type="radio"/> Yes | <input type="radio"/> No | Do you smoke? | <input type="radio"/> Yes | <input type="radio"/> No | Mental or Neurological Problems |

If "Yes" to any above, please describe: _____

Please list any **severe allergies** to foods, medications, insects, etc. (If none, please write "NONE"): _____

Please list any **medications** that you are taking (and what they are for): _____

I give permission for full participation in CWS programs, subject to limitations noted herein.

IN CASE OF EMERGENCY: I understand every effort will be made to contact me (if participant is an adult, my spouse or next of kin). In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by CWS to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child (or for me, if participant is an adult).

Participant Name (please print) _____ Date _____

Signature of Participant or parent/ guardian _____