MEDICAL INFORMATION FORM

Please print legibly with blue or black ink only

I. General Information

Student Name _____ Group Name _____

( ) Male ( ) Female Height _____ Weight _____ Birth Date ____/_____/_____

E-mail _____

II. Medical History

Last 6 months

Yes	No	**Asthma**	Yes	No	**Epilepsy**	Yes	No	**Back, Neck, Knee problems**
Yes	No	**Broken Bones**	Yes	No	**Diabetes**	Yes	No	**Pregnant** *(Just Current)*
Yes	No	**Heat Exhaustion**	Yes	No	**High Blood Pressure**	Yes	No	**Blacked Out**
Yes	No	**Chest Pains, Palpitations, or Heart Murmur**				Yes	No	**Heart Disease or Attack**

If checked YES, please described how you treated it and prevent it:

_____

_____

_____

We highly recommend that participants with asthma bring inhalers to the program date

1. Check any of the following *current* allergies.

___ Poison Ivy ___ Ants ___ Pollen ___ Bees ___ Grass ___ Medication ___ Other

If checked, please explain any allergic reaction (treatment, prevention, consequences)

_____

_____

2. Are you ***currently*** taking prescription medication, or over-the-counter?

YES **NO** Medication Name: _____ How Often: _____ Dosage: _____

3. Please add any relevant medical information you think could affect your participation

_____

_____

_____

III. Consent

I am aware of my past and present health and fitness condition when engaging in strenuous activity. I fully understand the rigorous nature of the Challenge Course program and I assume all responsibility, risk and liability pertaining to my physical condition.

_____ _____ _____ _____/_____/_____

Print participant name | Participant signature | Parent or Legal Guardian Signature (If participant is under 18 years old and NON UCF student) | Date