



## Challenge Course Medical Disclosure/Health Form

We require that this form be read and filled out in full before Participation.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_

Weight: \_\_\_\_\_

In case of an emergency please notify:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_

(cell) \_\_\_\_\_

Physician Name: \_\_\_\_\_ Physician

Phone: \_\_\_\_\_

Medical Insurance Carrier \_\_\_\_\_

Policy Number: \_\_\_\_\_

1. Have you received any pressure or coercion from others (friends, classmates, family, parents, coach or employer) to participate? Yes \_\_\_\_\_ No \_\_\_\_\_

2. Current exercise level: Type of Activities \_\_\_\_\_  
Frequency: \_\_\_\_\_

3. Do you foresee any problems participating in the upcoming challenge course activities due to lack of physical fitness? Yes \_\_\_\_\_ No \_\_\_\_\_

4. Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_.

5. Do you smoke? Yes: \_\_\_\_\_ No: \_\_\_\_\_

6. Do you have asthma: Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, is your asthma controlled: Yes: \_\_\_\_\_ No: \_\_\_\_\_

Do you have exercise or stress induced asthma: Yes: \_\_\_\_\_ No: \_\_\_\_\_

7. Do you wear glasses or contact lenses? Yes: \_\_\_\_\_ No: \_\_\_\_\_

8. Are you currently under a physician's care? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, What are you currently being treated for?

9. Are you currently taking any medication? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Medication(s): \_\_\_\_\_

Condition(s): \_\_\_\_\_

10. Do you have any allergies (food, bees, or medicines)? Yes: \_\_\_\_\_ No: \_\_\_\_\_

List: \_\_\_\_\_

Reaction: \_\_\_\_\_

Medication Required: \_\_\_\_\_

11. Do you have a disability? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please indicate the functional implications and any concerns about participation related to the disability.

12. Do you require special assistance of any kind? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, Please

explain: \_\_\_\_\_

13. Have you had a recent injury? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, Please

explain: \_\_\_\_\_

14. Do you have diabetes, seizures, or frequent fainting/dizziness? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, Please

explain: \_\_\_\_\_

15. Do you have any neck, back, shoulder, knee, or ankle injuries? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, Please

explain: \_\_\_\_\_

16. Do you have a history of heart problems and/or high blood pressure?

Yes: \_\_\_\_\_ (if you checked "Yes", please read the note below) No: \_\_\_\_\_

If yes, Please

explain: \_\_\_\_\_

\*Note: If "Yes": Blood Pressure: (taken within the last six months) \_\_\_\_\_

17. Do you have any other medical or psychological conditions? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, Please

explain: \_\_\_\_\_

**Participants with a history of heart problems and/or high blood pressure are at risk while participating on a challenge course due to the emotional and physical demands involved. Heart attacks and fatalities have occurred in situations where**

individuals with preexisting heart/high blood pressure conditions have participated in challenge course activities.

**\*\*We ask that all participants answering “Yes” to questions #3, 4, 14 and/or 16 and/or if they have severe or uncontrolled asthma to submit a written approval from their physician prior to participation.**

**General information regarding pregnancy:**

The activities involved in challenge course participation often involve twisting, turning, lifting, supporting body weights, unexpected physical contact, potential falling from various heights, and waist harness usage. By participating in these activities while pregnant, you will put yourself and your unborn child at risk and in potentially dangerous situations.

I have read the Camp Mokule‘ia, Inc. Health Form and fully understand it without question. I have honestly disclosed to the staff any medical, psychological or personal reasons that might affect my safety or the safety of others during the activities. I understand that I am participating by my own choice and that I do not feel pressured to participate. I certify that I have health insurance that will provide coverage in the event that I am injured.

The information I provided is accurate to the best of my knowledge.

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Signature of Parent/Legal Guardian (If participant is under 18) \_\_\_\_\_ Print

Name: \_\_\_\_\_ Date: \_\_\_\_\_