



Adventure Zone and Challenge Course Permission and Participant Health History

Only participants with a signed permission and health history forms may participate.

My child _____ has permission to participate
in _____ Date _____

The following information is provided so that the adult in charge may contact a responsible person in case of illness or accident during the activity.

_____	(_____)
Parent/guardian	Phone(s)
_____	(_____)
Parent/guardian	Phone(s)
_____	(_____)
Responsible person other than the above/relationship	Phone(s)
_____	(_____)
Doctor	Phone

My child is in good health and may engage in all activities [] yes [] no. If no, list any exceptions _____

In an emergency situation, an emergency medical technician may need to know the following information regarding my child's health (e.g., allergies, chronic illnesses, seizures, etc.) _____

Date of last tetanus shot _____

I give my permission for the adult in charge to take my child to a medical facility, if necessary. In case of emergency, if none of the above can be contacted, I consent to treatment for my daughter under the supervision of and as deemed advisable by a physician licensed under the Medicine Practice Act. This provides authority pursuant to Section 25.8 of the California Civil Code.

Parent or guardian's signature _____ Date _____

Participant Health History Record This health history is to be completed and signed by parents/guardians of participant or adult participant.

Participant's name:	Phone:	Name of family physician:
Family medical/hospital insurance carrier:	Policy or group no.	Physician phone: (_____)

Illnesses and injuries: (Check those that apply.)
 Ear infection Bleeding/clotting disorders Hypertension Asthma
 Heart defect/disease Musculo-skeletal disorders Seizures Diabetes Other (specify) _____

Other health conditions: (Check those that apply.)
 Bed wetting Emotional disturbances Constipation Fainting
 Menstrual cramps Hearing impairment Motion sickness Sickle cell trait or disease
 Nosebleeds Special dietary regimen Sleep disturbances Wears corrective eyewear
 Other (specify) _____

Are immunizations up to date? Yes No Is the participant currently taking prescription/over the counter medicine? Yes No

Is the participant currently: Under a physician's care Yes No Receiving psychological counseling Yes No Restricted in physical activity Yes No

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted.

Date of last health examination: _____ Were any complicating medical problems noted in last health examination? _____

List past medical treatments such as operations, treatment for serious injuries, diseases or disabilities, hospitalizations and dates:

List all allergies (food, medication, environmental, etc.), what reaction or symptoms, and what management treatment:

This health history is complete and accurate. I know of no reason(s), other than the information indicated on this form, why my minor child/I should not participate in prescribed activities except as noted.

I give my permission for the adult in charge to take my child to a medical facility for treatment. As an adult participant, I give my permission to be taken to a medical facility for treatment. In case of emergency, if none of the above can be contacted, I, the undersigned, consent to allowing treatment under the supervision of and as deemed advisable by a physician licensed under the Medicine Practice Act. This provides authority pursuant to Section 25.8 of the California Civil Code.

Parent of minor/Adult Participant Signature _____ Date _____