

# ADVENTURE EXPERIENCES, INC. HEALTH HISTORY FORM

(Please Print Neatly)

The proposed program provided by Adventure Experiences, Inc. requires participation in physical activities which are, by their nature, physically demanding. Many of the activities as well as being at high altitude will challenge you, both of which can cause surges in blood pressure and heart rates. It is imperative that you are free of any heart related or other diseases. Therefore, all participants must be free of medical or physical conditions which might create undue risks to themselves or any others who depend on them. Good physical condition will increase your enjoyment of the outdoor activities. **As required by the State of Colorado, participants under the age of 18 must submit a statement confirming a physical examination within the last 24 months by a physician or nurse practitioner.**

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

**Health History:** (Circle the appropriate response and describe any yes answers)

Have you had or do you currently have any heart problems, i.e., strokes, heart attacks, and/or heart related diseases? YES NO

Do you frequently suffer from pains/pressure in your chest? \_\_\_\_\_ YES NO

Do you often feel faint or have spells of severe dizziness? \_\_\_\_\_ YES NO

Has a doctor ever told you that you have high blood pressure? \_\_\_\_\_ YES NO

Are you a smoker? \_\_\_\_\_ YES NO

**(NOTE: If you have had any heart related problems you will need to have a release from a physician in order to participate in any camp activities.)**

Do you have arthritis, joint or back problems that might be aggravated by exercise? \_\_\_\_\_ YES NO

Have you had any operations, serious injuries or illnesses? (dates) \_\_\_\_\_ YES NO

Do you have any disabilities or communicable diseases? \_\_\_\_\_ YES NO

Are you allergic to any medicines, insects or pollen? \_\_\_\_\_ YES NO

Are you allergic to any foods? \_\_\_\_\_ YES NO

Do you have Asthma? \_\_\_\_\_ YES NO

Do you have Epilepsy? \_\_\_\_\_ YES NO

Do you have Diabetes? \_\_\_\_\_ YES NO

Do you have any prescribed meal plan or restrictions? \_\_\_\_\_ YES NO

Are you currently sick and/or using a medication not listed above? \_\_\_\_\_ YES NO

List any activities to be limited or prohibited \_\_\_\_\_

Suggestions or health related information for A.E. Personnel: \_\_\_\_\_

**General Health Statement:** \_\_\_\_\_

## REPRESENTATION AND EMERGENCY AUTHORIZATION

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the medical personnel selected by Adventure Experiences, Inc., or it's agents to order x-rays, routine tests and treatment as well as injection and/or anesthesia and/or surgery for me or my child as named above. Such authorization for emergency treatment shall also include, but not be limited to, charges incurred for the providing of aid and arranging evacuation if Adventure Experiences, Inc., or its agents, determine that such evacuation is necessary or desirable. I further agree to assume responsibility for the costs of any specialized means of evacuation and of any medical care and acknowledge that these costs are the financial responsibility of the undersigned. I also understand and agree to abide with the restrictions placed on my camp activities.

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

Signature of Parent/Guardian (if under 18): \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_