River's Way Outdoor Adventure Center

Health Information Form

Participant's Name:_____ Date of Birth:_____ Age:___

Address:_____ City:_____

State:_____ Zip Code:_____ Home Phone:(____)_____

Email:_____

Parent/Guardian's Name (for participants under 18):_____

Work Phone:(____)_____ Home Phone (if different):(____)_____

Insurance Carrier/Policy #:_____

Participant Health Information

Please complete the following information as completely and accurately as possible. This form is confidential and the information will help River's Way staff provide the best possible medical care in the event of an emergency. Any errors or omissions could result in improper treatment or further exaggerate injuries or illnesses.

Do you have any allergies?___ If yes, please explain…_____
_____
_____

Are you currently taking any medications?___ If yes, please explain…_____
_____
_____

Are there any restrictions on your activity or behavior?___ If yes, please explain..._____
_____
_____

Do you have any special needs (dietary, disability, etc)?___ If yes, please explain…____
_____
_____

What was the date of your last Tetanus Shot?_____

Have you had any recent injury or illness?___ If yes, please explain…_____
_____

In the event of a medical emergency, I give permission to River's Way, their staff, and/or designated personnel to administer or secure proper treatment, and/or hospitalize my child, or me if necessary.

Participant Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____
(for participants under 18 yrs. of age)