

MEDICAL INFORMATION/INFORMED CONSENT

Name: _____

First name M.I. Last name

Telephone: (_____) _____ (_____) _____

Home Work

Name of personal Physician: _____ phone (_____) _____

In case of emergency please contact: _____ phone (_____) _____

Special diet considerations: _____

List known allergies: _____

If you are allergic to bee stings, do you have a bee sting kit? _____

List required medications: _____

Do you wear contact lenses? _____ Are you pregnant? _____

Have you ever had or do you now have (circle if yes):

Diabetes Asthma Angina Epilepsy Chest pain Drug reactions High blood pressure Heart murmur

Heart attack (If yes to any of the above, date): _____

Have you ever had any serious disease or surgery? (If yes, explain and include date.)

Do you have any other medical conditions that we should be aware of? _____

I am not under the influence of any chemical substance including alcohol. Understanding that any physical activity involves risk of injury, I understand that my participation in the Last Frontier Council is entirely voluntary. I release Last Frontier Council, its' employees and staff, from any claims or liability arising out of my participation. This release does not, however, apply to any harm caused by negligence or willful misconduct of Last Frontier Council or its employees.

Name (please print)

Course/Company

Signature

Date

*If the participant is under the age of 18, their parent or guardian must also sign below.

Parent or Guardian _____

Signature

Date