Kent Mountain Adventure Center, Inc.
P.O. Box 835
Estes Park, CO 80517
(970) 586-5990

Participant Medical Form

COMPLETED FORM IS REQUIRED
*Note: If participant(s) are under the age of 18 a separate Medical Form is required.

Participant Name: _____ Age: ____ Date of birth: _____/_____/_____

Address/P.O. Box: _____

City: _____ State: _____ ZIP: _____

Cliff Camp Date: _____

M _____ F _____ Height: _____ Weight: _____ Last physical exam: _____/_____/____

Emergency Contact Name: _____

Day phone: (_____)_____ Night phone: (_____)_____

Second emergency contact Name:

Day phone: (_____)_____ Night phone: (_____)_____

HEALTH HISTORY

List any chemical or drug allergies (penicillin, sulpha, iodine, etc.): _____

_____
___

List any allergies: food (nuts, fish, peanut butter, dairy, etc.), insects (bee stings, etc.), hayfever (pollen, mold, etc.):

Has participant ever been stung by a bee/wasp: Yes ❑ No ❑

Has participant ever exhibited a genuine fear of heights? Yes ❑ No ❑

Does the participant have a history of any of the following: Please check all that apply:

❑Asthma ❑respiratory disorder ❑fainting ❑dizziness ❑diabetes ❑hypertension
❑Seizure disorder ❑headaches ❑sleep walking ❑ Anxiety ❑heart disease/defect

Does the participant have any other pre-existing medical conditions? Please list:_____
_____
____

Special diet?:
_____

Past history of injuries (include dates):
_____

_____
___

Participant's Doctor: _____ Phone: (_____) _____

In case of an emergency I hereby give my permission to the physician selected to hospitalize and secure proper treatment for myself and other members of my party.

Signature of participant: _____ Date: _____

Medical Health Insurance: Company: _____

Address: _____

Policy #: _____ Group #: _____ Phone: (_____) _____

If there are <u>any</u> changes in the participant's medical status between now and the course dates, please contact KMAC with the new information: (970) 586-5990.