

# ***Front Range Climbing Company***

## **Participant Health Statement & Authorization for Medical Treatment**

NAME: \_\_\_\_\_

Program Participating In: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP : \_\_\_\_\_

PHONE: (H) (\_\_\_\_) \_\_\_\_\_ (W): (\_\_\_\_) \_\_\_\_\_ DATE OF BIRTH: \_\_\_ / \_\_\_ / \_\_\_

\* Please complete the following as thoroughly as possible. The information will be used only by the program leaders and any emergency medical personnel. All material is confidential.

HEALTH INSURANCE CO. & POLICY NUMBER \_\_\_\_\_

Do you have any physical disabilities or conditions: YES / NO  
(Heart conditions, diabetes, seizures, etc.) that may/will affect your participation? Please include any allergies (bees, food, etc.):

If 'YES', please list disabilities or conditions:

Are all immunizations current (tetanus, booster, etc...)? YES / NO

Name or family physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Emergency Contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address : \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP : \_\_\_\_\_

In the event that I am rendered unable to communicate due to illness, accident, or emergency while participating, I hereby give permission to the Physician, selected by the program personnel, to hospitalize, secure proper treatment for, and to take whatever medical actions necessary to treat me.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Full Name (Printed)

\_\_\_\_\_  
Parent/Guardian Signature if under 18 years of age

\_\_\_\_\_  
Date