Medical Information for Climbing and Rappelling

Name ____
First   Middle initial   Last

Telephone (_____) ______________________ (_____) ______________________
Home   Work

Personal physician ______________________ Phone (_____) ______________
Name

In case of emergency, please contact ______________________ Phone (_____) ______________

Special dietary considerations: ____

____

List known allergies: ____

____

List required medications: ____

____

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

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Do you wear contact lenses? __________ Are you pregnant? _____ Afraid of Heights or Edges? __________

Have you had or do you now have (circle if yes): Heart Disease Diabetes Asthma

Nerve/Muscle Problem Epilepsy Chest pains Drug reactions High blood pressure

Bone/Joint Problem

If you answered "yes" to any of the above, explain and include a date: ______________________

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Do you have any other medical conditions that might interfere with your ability to participate in strenuous physical activity of climbing or rappelling or to follow directions? ______________________

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