Last Name: _____

Session Date: _____

Lehigh University Low Ropes Course

LEHIGH UNIVERSITY ROPES CHALLENGE COURSE
Medical Information Form

Please complete this form before arriving for your Ropes Challenge Course Session. The medical information that you are providing will be kept confidential. It will not be released to anyone without your permission, except in an emergency where you are unable to otherwise communicate your wishes.

PERSONAL INFORMATION

Last Name: _____ Middle Name: _____

First Name: _____ Date of Birth: _____

Address:_____ Home Phone: _____

City, State, Zip: _____ Cell Phone: _____

Organization: _____ Work Phone: _____

EMERGENCY CONTACT INFORMATION

In case of emergency, please provide contact information for who we should notify.

Contact Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

MEDICAL INFORMATION

Medical/Health Insurance Co.: _____ Policy/ID Number:_____

Allergies:_____

If you are taking any medications, please list them here:_____

SIGNATURE(S)

I certify that the above information is correct and that the medical/health insurance policy listed above will remain in full force and effect at the time of my participation in the Lehigh University Ropes Challenge Course.

_____ _____

Signature of Participant *Date*

_____ _____

Signature of Parent/Guardian *Date*
(if participant is under 18 years of age)