Participant Information Form

Trip Date: ________________ Group Name: _____________________________

Personal Information

Name:____ M __ F__

Age: _____ d.o.b.___/___/______ Height*:_____ Weight*: _____ Shoe Size*: _____

*For climbing harness & other sizing

Address:____

City:____________________________ State: ______________)_ Zip: __________

Phone Number: (____)_____-_________ E-Mail:______________________________

Do you have any medical or physical conditions that could affect your safety/health on the trip?

___Yes ___No Please explain any conditions: ___________________________________

____

Do you have Allergies/ take any Medications? ___Yes ___No

Please Explain: ____

Are you allergic to bee stings?___Yes ___No Certain foods/ingredients? ___Yes ___No

Please Explain: ____

Do you have any physical mobility issues: ___Yes ___No

Please Explain:____

Do you have any other restrictions or concerns we should know about?

____

____

In Case of Emergency:

Physician's Name:___________________________________ Phone:(____)_____-________

Emergency Contact Name: ____________________________ Relation:______________

Phone: (____)_____-_________

What do you hope to learn/ get out of this day?:

____

____

____

☐ I certify that the information on this form is true, accurate, and complete.

Signature of Participant:______________________________ Date: ____________

Signature of Parent or Guardian ________________________ Date: ____________

(If participant is less than 18 years of age)

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