

# Confidential Participant Health Information

## Denver Parks and Recreation - Outdoor Recreation

### ALL GROUP LEADERS & PARTICIPANTS MUST FILL OUT

Denver Parks and Recreation and Genesee Experiential Outdoor Center provide recreational opportunities for youth/adults to hike, camp, and/or participate on a challenge course. This program can involve strenuous physical activity and may place you/ your child in physically, emotionally and mentally stressful situations. It is important that all participants be in generally good physical condition. Due to the level of physical exertion involved, anyone with health concerns should not participate. Consult with your physician before participating in any physical program.

#### Please complete all of the following information:

PROGRAM DATE: \_\_\_\_/\_\_\_\_/20\_\_\_\_ Organization/school \_\_\_\_\_

Participant name \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex M or F

Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone # \_\_\_\_\_ Other phone # \_\_\_\_\_

Parent/Guardian name (please print) \_\_\_\_\_

Other Emergency Contact name \_\_\_\_\_ phone # \_\_\_\_\_

#### Do you/your child have medical coverage? YES or NO

If yes, name of Company \_\_\_\_\_ & Policy number \_\_\_\_\_

Doctor name and phone # \_\_\_\_\_

I, the undersigned parent or guardian of the above named participant do hereby give my consent, in the event all reasonable attempts by authorized medical personnel to contact me at the phone numbers listed above have been unsuccessful, for

- \* 1. Administration of pre-professional care to the level of training of the recreation program's employee
- \* 2. The administration of any treatment deemed necessary by a licensed physician.
- \* 3. To transfer the participant to a hospital that is reasonably accessible.
- \* 4. I agree that I am solely responsible for payment of all costs resulting from medical and ambulance services.

This authorization does not cover major surgery unless the medical opinion of a second licensed physician concurring in the necessity for such surgery is obtained prior to the performance of such surgery.

#### The following information is provided to assist personnel to administer medical attention to me and/or my child or ward:

Does participant have (or had) any of the following conditions? Circle **Yes** or **No** to each, explain as needed

YES	NO	fainting	YES	NO	earache/ear infection(s)
YES	NO	asthma/respiratory problems	YES	NO	heart problems
YES	NO	diabetes	YES	NO	seizures
YES	NO	stomachaches	YES	NO	major illness this past year
YES	NO	operations/surgery	YES	NO	psychological problems
YES	NO	last tetanus shot _____	YES	NO	food allergies
YES	NO	previous injuries (head/back/broken bones)	YES	NO	other allergies (bee stings, medication)
YES	NO	high blood pressure	YES	NO	elevated cholesterol

PLEASE explain any of the above \_\_\_\_\_

YES NO Has a doctor instructed the participant to limit their activity in any way? \_\_\_\_\_

YES NO Is the participant taking any medications (please list) \_\_\_\_\_

**PLEASE BRING ANY MEDS THAT MAY BE NEEDED** (Staff is not permitted to dispense any medications)

Participant / Parent Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_