



CHALLENGE COURSE PERMISSION SLIP/WAIVER

I/We recognize that there are potential risks inherent in both high and low challenge course activities, including the risk of serious injury or death, and including the possibility of slips, falls, pinches, scrapes, twists and jolts that could result in bruises, sprains, lacerations, and fractures. During participation in the program, a participant may also make contact with plants or insects that could create hazards such as allergies. I/we certify that the program participant is capable of participating in this program; therefore, I/we agree to assume full responsibility for any bodily injury that may result from the inherent risks and for my/my child's own negligence, if any, while participating in the program.

Knowing and recognizing these facts I/we expressly assume all risk of injury or death to me or my minor child, and as an inducement for Brethren Woods allowing me to participate in this activity, I/we waive my/our rights to sue, maintain action against, or recover from a Challenge Course activity sponsor (Brethren Woods), staff person, or other Challenge Course leadership thereof for any bodily injury or death due to any cause whatsoever arising from my participation in this activity. Furthermore, I agree to indemnify and hold harmless all of the foregoing from any claims which I might make or which might be made on my behalf by others arising from my participation in such activity.

In addition, groups providing their own transportation to and from the Challenge Course location assume all risk in their travels.

Participant's Signature

Participant's name in print

I am the parent or guardian of _____, a minor, and on the child's behalf and on behalf of me and all other parents or guardian of the child, I accept the above release and waiver of liability as inducement for allowing the child to participate in the above-described activity. I further authorize any emergency medical care which may be necessary. I represent that I have the authority to give this release.

Signature of Parent/Guardian if participant is a minor

Date

EACH PARTICIPANT MUST HAVE SIGNED AND COMPLETED WAIVER (BOTH SIDES) ON DAY OF ACTIVITY OR THEY MAY NOT PARTICIPATE.

PERSONAL MEDICAL HISTORY

IMPORTANT—Please be thorough in providing the information requested. Failure to disclose information could result in serious harm to you as a participant in this program. Please do not forget to read and sign the opposite side of this sheet. All information will be kept confidential.

IF YOU CHECK YES TO ANY QUESTION BELOW, DESCRIBE PROBLEMS IN DETAIL ON THE RIGHT SIDE OF THE FORM.
Attach an additional sheet if necessary.

Check One

Description

- | | |
|-------------|--|
| Yes___No___ | 1. Do you have any present medical problems or physical limitations? Describe. |
| Yes___No___ | 2. Does your health prevent you from participating in any physical activities? (Describe.) |
| Yes___No___ | 3. Are you taking any prescription or non-prescription medications? (List all and reasons for taking.) |
| Yes___No___ | 4. Have you had any surgeries or been hospitalized for any reason? (Describe and give approximate dates.) |
| Yes___No___ | 5. Are you allergic to any insect bites or medications? |
| Yes___No___ | 6. Do you smoke? (If so, how much?) |
| Yes___No___ | 7. Do you have impairments of vision or hearing? |
| Yes___No___ | 8. Have You ever been diagnosed as having high blood pressure? Are you currently under treatment for high blood pressure? |
| Yes___No___ | 9. Do you have heart murmurs, episodes of irregular heart beat, shortness of breath or chest pain on exertion? |
| Yes___No___ | 10. Have you ever been diagnosed as being at risk for heart disease? Is there any history of heart disease in your family? |
| Yes___No___ | 11. Are you engaged in a regular program of exercise? (Describe exercise and frequency.) |
| Yes___No___ | 12. Do you have asthma? (Describe) |
| Yes___No___ | 13. Do you have diabetes, thyroid trouble or other endocrine problems? (Describe history & symptoms.) |
| Yes___No___ | 14. Have you had or do you have ulcers, heartburn, or other intestinal disorders? (Describe.) |
| Yes___No___ | 15. Have you ever had seizures? (Describe & give date of last seizure) |
| Yes___No___ | 16. Do you have problems with your neck, back, arms, shoulders, ankles or knees that would limit your activities? (Describe symptoms & limitations.) |

17. Date of your last tetanus booster: _____ 18. Birth Date (mo/day/yr): _____

Persons to be contacted in case of serious illness or injury:

Name, Address & Relationship (_____) Telephone Number

Name, Address & Relationship (_____) Telephone Number

Name, Address & Relationship (_____) Telephone Number

Name of Insurance Co.: _____ Medical Insurance Plan Number: _____