



X \_\_\_\_\_  
Parent/Guardian signature Date Emergency Phone Number (s)

River/Program Name: \_\_\_\_\_  
Date: \_\_\_\_\_

### Wild Waters Outdoor Center Medical History Report

Please print and fill out **COMPLETELY**:

PARTICIPANT'S NAME:(please print) \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ Email address: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

Do you presently have, or have you ever had any of the following:

Diabetes Yes \_\_\_\_\_ No \_\_\_\_\_

Heart Disease Yes \_\_\_\_\_ No \_\_\_\_\_

Asthma Yes \_\_\_\_\_ No \_\_\_\_\_

Epilepsy Yes \_\_\_\_\_ No \_\_\_\_\_

High/Low Blood Pressure Yes \_\_\_\_\_ No \_\_\_\_\_

Shoulder Dislocation/Subluxation Yes \_\_\_\_\_ No \_\_\_\_\_

Allergies (bee stings, food, etc.) Yes \_\_\_\_\_ No \_\_\_\_\_

If YES to any of the above, do you carry medication and what type? \_\_\_\_\_

**If YES to BEE STING, please make sure you bring your own bee sting kit!!!**

Do you wear contact lenses? Yes \_\_\_\_\_ No \_\_\_\_\_

Has your physical activity been restricted or altered during the past 5 years?

Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, give reasons why: \_\_\_\_\_

Have you had any recent significant illness or injury or been hospitalized other than already noted?

Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, give reasons why: \_\_\_\_\_

Please rate your swimming ability: Beginner \_\_\_\_\_ Intermediate \_\_\_\_\_ Expert \_\_\_\_\_

Are you presently on any medication other than already noted?

Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, please explain: \_\_\_\_\_

Do you have any medical problems that might exclude you from participating in vigorous physical activity?

Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, please explain: \_\_\_\_\_

In case of emergency, please contact (name): \_\_\_\_\_

Telephone #: \_\_\_\_\_