

Part I – General History

Name: _____

Sex: Male___ Female___ Date of Birth: _____

Name of Insurance Carrier: _____

Address: _____

Part II – Medical Information

Do you have any disabilities (temporary or permanent) that your doctor feel would limit your participation in the Adventure Training Program? Yes___ No___ If you answered Yes, please explain.

Please list any medications you are currently taking and conditions they are treating. If none, so state.

Do you have allergies? Yes___ No___ Reactions to medications? Yes___ No___

Other medical limitations? Yes___ No___ If you answered Yes to any part of this question, please explain:

Part III – Medical History

Have you had surgery in the past year for any conditions that might limit your participation? Yes___ No___

If you answered Yes to any part of the question, please provide details.

If you answered Yes to any part of the Medical History questions above, The Adventure Training Program strongly recommends that you see a physician before participation.

Do you have Diabetes? Yes___ No___ If you answered Yes, are you dependent on insulin? Yes___ No___
Is there is a history of heart disease in your family? Yes___ No___ If you answered Yes, please elaborate:

Do you smoke? Yes___ No___ Are you a former smoker? Yes___ No___ If you answered Yes, when did you stop? _____

How often do you exercise? No regular exercise___ 1-2 times/week___ 3+ times/week___
If you lead a sedentary lifestyle, smoke, are overweight, have diabetes or are 45 years of age and have a family history of heart disease, the Adventure Training Program strongly recommends that you consult your physician before participation.

If you are unclear about whether to consult your physician or you or your physician would like more information regarding the activities included in your program, please contact Adventure Training Program staff.

I have consulted my physician. Yes___ No___
My physician advises me that I may participate fully. _____
My physician has advised me to avoid certain activities. _____
My physician advised me not to participate. _____

If your physician has limited or disapproved your participation, please provide further details:

I recognize the inherent risk of injury or disability associated with the Adventure Training Program activities and I agree to assume that risk. I further agree to follow all of the Adventure Training Program's safety instructions. I hereby release the Adventure Training Program, Hudson Valley Community College, its officers, employees, Board of Trustees, SUNY, and the County of Rensselaer from liability for any injury to me from participation in the Adventure Training Program activities. In the event of illness or injury, consent is hereby given to provide emergency medical care, hospitalization and treatment, which may become necessary.

In the event of injury or illness, please contact:

Name: _____ Relationship: _____

Address: _____

Daytime Phone: _____ Evening Phone: _____

I understand that failure to answer this questionnaire in a full and comprehensive manner could affect my own safety as well as that of others, and therefore I affirm that the information herein is accurate and complete. I agree to hold the Adventure Training Program harmless if full disclosure of a pre-existing medical condition has not been made.

Participant Signature: _____ Date: _____

Signature of Parent or Guardian (if Participant is under 18 years of age): _____

Name of Workshop: _____ Date(s) of Workshop: _____

I hereby grant the Adventure Training Program permission to use, reproduce, or distribute any photographs, films, videotapes and/or sound recordings of me during my training for use in materials it may create.

Participant Signature: _____ Parent/Guardian Signature: _____

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