

Appalachian Mountain Institute

Medical Form

AMI requires a medical history of each participant in case of an emergency. This form will remain private and will not be shared with any individual or agency, unless an emergency arises and this information is needed for emergency medical services. Please complete this form as accurately as possible.

Participant Name _____ DOB _____

Emergency Contact

(1) Name _____ Relation _____
phone_(____)_____ phone_(____)_____

(2) Name _____ Relation _____
phone_(____)_____ phone_(____)_____

Medical History

Have you had any muscular or skeletal conditions (joints, back, surgeries, etc) that may affect your ability to participate in this activity? **No / Yes, explain**

Do you have any medical conditions that AMI needs to be aware of such as diabetes or asthma? Do you need an inhaler? **No / Yes, explain**

Do you have any allergies to medicine, seasonal allergies, bee stings or food? **No / Yes, explain**

⇩ **Over** ⇩

Do you have a heart condition? Have you ever had a heart attack?

No / Yes, explain

What medicines are you currently taking? Please give the name and reason for taking the medicine. (None)

Name _____ *Reason* _____

Drug and Alcohol Policy

At no time during this activity will any participant be under the influence of drugs or alcohol or take any substance that may otherwise impair your ability to function at a normal and reasonable level. AMI reserves the right to terminate activities if the participant is under the influence.

(initial) _____

Physical Disclaimer

Climbing and all related activities are strenuous and require a reasonable level of fitness and athleticism to participant. Related activities include hiking distances uphill, carrying equipment, and moving over uneven terrain. The participant should be realistic with what he or she is able to do and AMI is not responsible for the participant's level of preparedness for the activity. (initial)_____

Medication disclaimer

The use of over-the-counter medication, such as, acetaminophen, ibuprofen, aspirin, and any other over the counter medicine is solely the choice of the participant and I (name) _____ accept responsibility for the use of any OTC medicine regardless of the source of medicine. (initial) _____

I (print name) _____ have read this form and have completed the medical information to the best of my knowledge, and I am solely responsible for providing accurate information to AMI.

Signature _____ Date _____

Signature of Guardian if under 18 years of age.

Signature _____ Date _____