6295 Busch Blvd \ Columbus, OH 43229 \ 614 888-8393
verticaladventuresohio.com

Health History, Emergency Contact Information Permission to Treat with First Aid and Medical Authorization

Child Name: ______________________________

Address: ______________________________

Mother/Guardian's Name: ______________________________

Day Phone ( ) ______________ Evening Phone ( ) ______________

Father/Guardian's Name: ______________________________

Day Phone ( ) ______________ Evening Phone ( ) ______________

Emergency Contact: ______________________________

Day Phone ( ) ______________ Evening Phone ( ) ______________

PLEASE FILL OUT EITHER SECTION ONE (CONSENT FOR MEDICAL TREATMENT) OR SECTION TWO (REFUSAL OF CONSENT FOR TREATMENT). THE REVERSE SIDE OF THIS FORM CONATINS MEDICAL HISTORY INFORMATION WHICH SHOULD BE COMPLETED AND ACKNOWLEDGED BY THE PARENT OR GUARDIAN OF THE MINOR CHILD.

Section 1

Authorization to permit medical treatment. By signing below, I hereby give permission to the Vertical Adventures, their employees, members, or volunteers to provide routine first aid and to supervise self-medication and to seek medical assistance on behalf of my child in the event my child is injured or becomes ill, and I am unavailable to indicate my wishes regarding treatment. I understand that the Vertical Adventures and its members, volunteers, or employees shall not be held responsible for the cost of treatment, and in fact are authorized to bind me as the financially responsible party for the medical treatment of my child. I hereby grant permission to physicians and other licensed health care providers and their designees to administer medical care through injury or illness evaluation, first aid care, and referral to duly licensed medical personnel when indicated.

____

Date Granted Signature of Parent Guardian

Section 2

Refusal to consent to medical treatment. By signing below, I indicate that Vertical Adventures Its volunteers, or employees are not authorized to allow the administration of health care to my child in the event of injury or sickness. However, I will not hold the Vertical Adventures, its employees, members, or volunteers liable in any way for seeking emergency care (such as calling 911) for my child or providing any health information on this form to emergency personnel.

____

Date Granted Signature of Parent Guardian

MEDICAL HISTORY INFORMATION MUST BE COMPLETED ON THE REVERSE SIDE OF THIS FORM.

VERTICAL ADVENTURES

TAKING FITNESS TO NEW HEIGHTS

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Health History (check. Please explain any check marks.)

_______ Frequent Ear Infections ______________________________

_______ Frequent Headaches ______________________________

_______ Heart Defect/Disease ______________________________

_______ Convulsions ______________________________

_______ Seizures ______________________________

_______ Diabetes ______________________________

_______ Bleeding/Clotting Disorders ______________________________

_______ Hypertension ______________________________

_______ Musculoskeletal Disorders ______________________________

_______ Other (specify) ______________________________

Allergies (Specify allergic reaction and management of the reaction)

_______ Animals (Animal and reaction) ______________________________

_______ Hay Fever ______________________________

_______ Posion Ivy ______________________________

_______ Insect Stings (insect and reaction) ______________________________

_______ Does your child have an Epi Pen and know how to use it? ______________________________

_______ Penicillin ______________________________

_______ Other Medication/Drugs ______________________________

____

_______ Asthma ______________________________