Ropes Challenge Course **- Participant Information -** ***Please Print***

Program Name/Organization: _____

Name: _____ Date of Birth: _____

Address: _____City, State, Zip _____

Home Phone: _____ Cell: _____ Work: _____

In case of Emergency who should we contact? Name: _____ Phone_____

Do you have health/accident Insurance? Yes ( ) No ( )

If Yes, name and address of company _____ Policy # _____

Do you have any limiting physical disabilities or handicaps (temporary or permanent)? Yes ( ) No ( ) If yes, please explain: _____

Do you have any of the following conditions?

( ) NO ( ) YES Seizure within the past one (1) year
( ) NO ( ) YES Neck, back, shoulder, knee or ankle problems
( ) NO ( ) YES High Blood Pressure or Heart Condition
( ) NO ( ) YES Abnormally high cholesterol level
( ) NO ( ) YES Coronary artery by-pass angioplasty
( ) NO ( ) YES Unexplained chest pain, pressure, shortness of breath, heart palpitations, sweats, dizziness, or fainting spells
( ) NO ( ) YES Kidney Transplant

If yes to any of these questions please explain: _____
Are you currently taking medication (prescribed or otherwise example: cold medication)?
( ) NO ( ) YES If yes, state what you're taking and for what condition_____
_____

Do you have any allergies, reactions to medications, or other medical limitations?
( ) NO ( ) YES If yes, please identify and explain_____

Are you allergic to bee stings? ( ) NO ( ) YES
If yes, do you carry an Epipen or your own medication? ( ) NO ( ) YES

I, the undersigned, do hereby waive and hold harmless The Town of Manchester, its employees and agents, from any personal or property damage I or my child may incur while participating in this activity. I also understand that The Town of Manchester does not provide accident or health insurance.
Parent / Guardians Signature: _____Date: _____

If participant is under 18, please complete:
As with any activity, I am aware that certain risks of injury may exist. Should an injury or accident occur, I _____grant permission for
Parent/Guardian
_____to receive treatment by a licensed or certified medical
Son/Daughter
personnel at the nearest medical facility. I recognize that I will be called immediately at the above phone numbers.

Parent/Guardian Signature: _____Date: _____