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Health and Safety Form

Adventureworks! is committed to delivering unique and exciting learning experiences that lead to positive growth and development in all individuals, groups, organizations and communities. Because of the physical nature of our programs, and because most programs take place in the outdoors, all participants are required to provide accurate health and medical information. In cases where there is some concern about one's ability to participate for health reasons, a medical examination by a physician may be advisable. Please note that Adventureworks! is not liable for any costs incurred during such an examination. All health information will be held in the strictest confidence and not given to a third party.

Please complete all sections:

Name of Group _____ Dates of Program _____

Name of Participant _____ Date of Birth _____

Home Address _____ City _____ Postal Code _____

Phone # (home) _____ Email address _____ OHIP # _____

Emergency Contact Name: _____ Relationship _____

Home Address: _____ City: _____ Postal Code _____

Phone # (daytime) _____ (evening) _____

Please list any disabilities, special needs, recent injuries, illnesses or operations and any subsequent limitations

Please list any medications, prescribed or otherwise, currently being taken

Please list any allergic reactions to medications, food or environmental factors:

Allergy	Reaction	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Epi Pen Required?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

NOTE: Please remember to bring your own EpiPen(s) if required.

Please describe any previous emergency treatment (injection, doctor, emergency room, hospital) in detail:

Authorization For Seeking Treatment of Minors

In the event of accident or apparent illness, I irrevocably authorize Adventureworks staff to secure emergency medical services and treatment for this participant if, in their judgment, such services or treatment are necessary. I understand that in the event of a medical emergency every effort will be made to contact parents or guardians.

Parent/Guardian _____ Signature _____ Date _____