

V2 HEALTH & PERMISSION TO TREAT FORM

Participant's Name _____ Age/Birth Date _____

Street Address _____ School _____

City _____ State/Province _____ Zip/Postal code _____

Home Ph. (_____) _____ Family Dr. Ph.(_____) _____

Father's Name _____ Work Phone (_____) _____

Mother's Name _____ Work Phone (_____) _____

If not available in an emergency, notify:

Name _____ Phone(_____) _____ Relationship _____

Medical Insurance Company _____ Policy Number _____

Participant's Medical History and Information

1. State of Health: List any Disabilities, Chronic Illnesses or Recent Injuries: _____

2. If participant must take medication to Vertical Ventures, send medication with original container and label. Please give the following information:

a. Name of medications _____

b. Times usually taken/Dosages _____

c. Reason for taking the medication _____

3. Allergies: Food, insect bites, drugs, other _____

4. Has he/she been exposed to any communicable diseases within the last ten days ? _____

If so what ? _____

5. Are there any physical activities in which he/she should not participate in? _____

6. Date of last tetanus shot, if known _____

7. Any other information we need to know about participant ? _____

Authorization (This section must be signed by parent / legal guardian and is required by Michigan state law. This health information is correct so far as I know and the participant referred to above has my permission to engage in all activities, except where specified by me above. I hereby give my permission to Vertical Ventures to secure emergency medical and surgical treatment and to provide routine non-surgical medical care for the participant named above, while participating in Vertical Ventures activities.

Signature: _____ Date: _____

Signed Parent/Guardian or participant if over 18 yrs. old

Vertical Ventures
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