

BRECKENRIDGE OUTDOOR EDUCATION CENTER

SHORT COURSE MEDICAL FORM

Disclosure of the following medical information is required before participation in a BOEC program. By law, the information you disclose is confidential. This information helps us screen applicants for medical issues that may pose a risk during programs and assists treatment in the event of an emergency.

Organization/School/Group Name: _____ Date: _____

Name & Title (title optional): _____

Age _____ Height _____ Weight _____ Sex M / F Date of Birth _____

Work Telephone: _____ Home Telephone: _____

Work Address: _____ Home Address: _____

Email: _____ Email: _____

In case of emergency, please notify: _____ Relationship: _____

All BOEC participants are responsible for personal medical fees or charges that are incurred during a program. We recommend that all BOEC participants be covered by personal medical insurance. If medical care is required during a BOEC program, for any reason, the participant or the participant's personal health insurance will be the primary insurance.

1. Are you aware of any physical, mental or sensory limitations that may affect your ability to participate? no yes
If yes, please explain _____

2. Are you currently taking medication (prescription or non-prescription)? no yes If yes, state what you are taking, and what condition(s) it is for: _____

3. Have you had any recent injury or illness? no yes If yes, please describe: _____

4. Do you have any history of heart, lung, or cardiovascular problems? (e.g. heart attack, asthma, heart disease, etc.)
 no yes If yes, please list and describe in detail any limitations: _____

5. Do you smoke? no yes

6. Do you exercise regularly? no yes If yes, please describe the type, frequency, and duration of your exercise program: _____

7. Are you allergic to any medicines or do you have any other serious allergies? no yes If yes, please describe: _____

ACCURACY OF INFORMATION AND PERMISSION TO OBTAIN MEDICAL TREATMENT ON MY BEHALF: I certify the accuracy of the above information and allow that should I become injured or ill, I give permission for the program staff to render first aid and to seek emergency medical or rescue services as they see fit, and at my cost.

→ _____
SIGNATURE (Required)

DATE

