

**COPE OR CLIMBING TOWER
MEDICAL INFORMATION CONSENT FORM
YOUTH AND ADULT**

Name _____
First Middle Last

Telephone _____
Home Work/Cell

Personal Physician _____
Name Phone

In case of an emergency, please contact _____
Name Phone

Special dietary considerations _____

List known allergies _____

Activity restrictions _____

If you are allergic to bee stings, do you have a bee sting kit? _____

Any vision or hearing problems? Yes or No If yes, please explain _____

Do you wear contact lenses? Yes or No Are you pregnant? Yes or No

Have you had or do you now have: Heart Attack Diabetes Asthma Angina Epilepsy

Do you have any other medical conditions we should be aware of? _____

It is understood and agreed that I am not under the influence of any chemical substance, including alcohol. Understanding that any physical activity involves risk of injury, I understand that my participation in the Chief Seattle Council's COPE program is entirely voluntary. I release the Chief Seattle Council, its employees and staff from any claims or liability arising out of my participation. This release does not, however, apply to any harm caused by negligence or willful misconduct of the Chief Seattle Council or its employees.

Signature of Participant _____
Date

Unit/Company/Organization _____
Date

Note: If the participant is under age 18, his or her parent or guardian must also sign below.

In case of an emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child.

Parent/Guardian Signature _____
Date

Emergency Number where I can be reached _____

For Council Use Only: Medical history reviewed by _____
Participant is Approved Not Approved, because of _____