

Eglin AFB Outdoor Adventure Medical Information

Please answer all of these questions truthfully and to the best of your knowledge. All information will be kept confidential.

Print Your Name Date of Birth

Height/ Weight

* Please list below any allergies you may have to certain foods, medications, insect bites or stings, pollen, etc.

* Please list below any medication or drugs, either prescribed or not, that you are currently taking or will be taking prior to or during the activity.

* Please list any ailments, injuries, or physical disabilities that would limit your ability to participate in the Outdoor Adventure Program activity.

*Has your physician been notified of your participation in this activity? Yes _____ No _____

*Emergency Contact Information:

Name: _____ Phone: _____

Address: _____

Thank you for your cooperation. This questionnaire must be returned to the Eglin Outdoor Adventure Program prior to the start date of the activity.

Signature

Date

Signature of parent or legal guardian
(if participant is under 18 years old)

Date

***Eglin AFB Outdoor Recreation reserves the right to deny participation to any individual we feel is not physically qualified for this event.**