Camp Mattatuck COPE & Climbing, Connecticut Rivers Council
MEDICAL INFORMATION/INFORMED CONSENT
To be completed by each participant

Name____
(First) (Middle Initial) (Last)

Address ____

City ______________________________ State__________ Zip Code____________

Telephone (_______) ______________________ (______) ______________________
(Home) (Work)

Personal Physician ____________________________ Phone (_____) ______________
(Name)

In case of emergency,
Please contact ____________________________ Phone (_____) ______________
(Name)

Special Dietary considerations____

List known allergies____

List required medications____

Are you allergic to bee stings? ______ Do you have a bee sting kit with you at all times? _______

Do you wear contact lenses? ________ Are you pregnant?____________________

Have you had or do you now have (circle if yes) heart attack diabetes asthma

angina epilepsy chest pains drug reactions high blood pressure heart murmur

If you answered yes to any of the above, explain and include date. ______________________________
____

Do you have any other medical condition that we should be aware of? __________________________
____

I am not under the influence of any chemical substance, including alcohol. Understanding that any physical activity involves a risk of injury, I understand that my participation in each of the activities of the Camp Mattatuck COPE program is entirely voluntary. I release Connecticut Rivers Council, its employees, and staff from any claim or liability arising out of my participation.

Name____ Group____________________
(Please Print)

Participant's signature*____________________________________ Date____________

*If the participant is under 18 years of age, his or her parent or guardian must also sign below.

Parent's or guardian's signature______________________________ Date____________