

NAU CHALLENGE COURSE

Confidential Medical form and Informed Consent Acknowledgement

Initials (everyone must initial, must be initialed by Parent/Guardian if Participant is under 18)

- _____ I acknowledge that I have been given the opportunity to participate in the Northern Arizona University Challenge Course(NAUCC) program and that I have been advised that I can decline to participate in this program if I wish.
- _____ I further acknowledge that I have been advised of the safety systems provided by the NAUCC, but that as with all physical activities, the potential exists for personal injury to me. Injury could include, but is by no means limited to, sprains, strains, broken bones, burns, lacerations, concussion, paralysis, and even death.
- _____ I am not now, nor will I be under the influence of, consume, any alcohol or any chemical substance during the program, except as disclosed on the Medical Information form returned by me to NAUCC.
- _____ I have decided to voluntarily participate in this program, or segments of the program, and in consideration of NAUCC accepting me into the program, I hereby waive and release all rights and claims which I may have against the State of Arizona, the Arizona Board of Regents, its members, employees, and agents, Northern Arizona University, NAUCC, their employees and agents for any and all injuries or damages suffered by me in participation in this program.
- _____ I understand that the State of Arizona, the Board of Regents, Northern Arizona University does not provide medical coverage if I am injured while participating in this event. Any medical costs incurred as a result of this activity will be my responsibility to pay.

General Information

NAU Student ID # _____

1. Name _____ Date _____
Address _____
Street _____ City _____ State _____ Zip Code _____
Home Phone Number () _____ Work Phone Number () _____
Male () Female () Age _____ Height _____ Weight _____
2. Group/Company Name _____
Address _____
Street _____ City _____ State _____ Zip Code _____
Phone Number () _____

Medical Information

1. Family Doctor _____ Office Phone Number () _____
Address _____
Street _____ City _____ State _____ Zip Code _____
2. Person to be notified in the event of illness or injury _____
Address _____
Street _____ City _____ State _____ Zip Code _____
Home Phone Number () _____ Work Phone Number () _____
Relationship to you _____
3. What is your insurance company's name _____
What is your policy number _____
4. Date of Last Tetanus Booster/Diphtheria Shot _____
5. Allergies (food, insect bites, bee sting, poison ivy, etc...) _____
Allergic Reactions _____
Medications to which you are allergic _____
6. Have you ever been hospitalized? YES NO
Date _____ Hospital Name _____
Address _____
Street _____ City _____ State _____ Zip Code _____
Reason _____

7. **Indicate YES or NO for each question:**

	Yes	NO		Yes	No		Yes	No
Angina Pectoris			Cancer			High blood pressure		
Any bad joint			Cardiac surgery			Irregular heart beats		
Asthma			Chest pain/pressure			Palpitations		
Bad back			Chronic illness			Pregnant		
Bad hips			Congestive heart failure			Seizures		
Bad knees			diabetes			Shortness of breath		
Bad shoulder			Frequent headaches			Stroke		
Black out spells			Heart attack (MI)			Thrombophlebitis		
Bleeding disorder			Heart murmur			Wolf Parkinson White		
Broken bones								

Regarding any items answered **YES**: Describe in detail with date and restrictions, if any _____

8. Do you carry a Medical Alert Bracelet Yes No If 'yes', reason _____

9. Are you currently taking any medications Yes No
If 'yes', What are they, Why, How often do you take them, & where are they? _____

10. Do you wear a support brace? Yes No Do you have it with you? Yes No

11. Do you smoke? Yes No

12. Describe your current exercise activity and level _____

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_____ The information provided here is a complete and accurate statement of the physical factors that may affect my participation in the NAUCC. I realize failure to disclose such information, or providing false information, could result in serious harm to fellow participants and/or myself.

_____ I agree to hold the State of Arizona, the Arizona Board of Regents, its members, employees, and agents, Northern Arizona University, NAUCC, their employees and agents harmless if all requested information is not disclosed truthfully.

_____ This information will be kept confidential except in case of emergency. In the case of emergency, this consent includes the release of medical and accident reports to insurance companies, my employer, or agency deemed appropriate by NAUCC.

_____ The information provided here is subject to NAUCC Staff screening and may require further assessment and medical clearance from a physician prior to participation in the activity.

_____ My initials next to this and preceding statements, in conjunction with signature(s) below, indicate my understanding and agreement of each statement.

Print Full Name

Signature

Date

Signature of Parent or Guardian (if under 18)

Date

*Failure to have a completed medical form will result in the individual being excluded from course participation in full, parent or guardian must initial and sign where it is required.