

**C.O.P.E. OR CLIMBING TOWER  
MEDICAL INFORMATION/INFORMED CONSENT FORM  
YOUTH AND ADULT (SCOUT & NON-SCOUT)**

Name \_\_\_\_\_  
(Please print) (First) (Middle) (Last)

Telephone (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
(Home) (Work)

Personal Physician \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
(Name)

In case of 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?  Y  N If yes, please explain: \_\_\_\_\_

Do you wear contact lenses?  Y  N Are you pregnant?  Y  N

Have you had or do you now have (check one):  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 a risk of injury, I understand that my participation in the Heart of Ohio Council's COPE program is entirely voluntary. I release the Heart of Ohio 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 Heart of Ohio Council or its employees.

Signature of Participant \_\_\_\_\_ Date \_\_\_\_\_

Unit/Company/Organization \_\_\_\_\_ Phone \_\_\_\_\_

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

In case of 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's or guardian's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Emergency number where I can be reached:** \_\_\_\_\_

For Council use only:  
Medical history reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_ COPE Director's Initials \_\_\_\_\_  
Participant is  Approved  Not Approved, because of \_\_\_\_\_