HEART OF OHIO COUNCIL BOY SCOUTS OF AMERICA

COPE OR CLIMBING TOWER
MEDICAL INFORMATION CONSENT FORM
YOUTH AND ADULT

Name_____
First Middle Last

Telephone (___) _____ (___) _____
Home Work

Personal Physician_____
Name Telephone

In case of an emergency, please contact_____
Name Telephone

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 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_____
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_____