ROCK DIMENSIONS, INC.
REGISTRATION AND MEDICAL FORM

Name: ____ Age: ________ Today's date: _____________

Address: _____________________________ City: __________________ State: _____ Zip: ________

Telephone: Home: ________________________ Work/Mobile: ______________________________

*If you would like to receive information about Rock Dimensions upcoming programs & events, please provide us with your **E-mail address**: ____

Name of personal physician: ______________________________ Phone: _______________

Emergency Contact: _____________________________________ Phone: _______________

Health/Accident Insurance Company: ____

Policy Number: ____

Have you ever had a kidney transplant? _________________ Are you pregnant? _________________

Do you suffer from asthma? __________Do you have an inhaler that you carry with you? __________

(*Asthmatics should bring an extra inhaler).

Have you ever had any heart problems? (heart attack, chest pains, surgery) ______________________

- Date and Explanation: ____

Allergies: ____

Medications: ____

Pre-existing injuries: ____

Do you have any other medical problems? ____

*****All participants are expected to take responsibility for their own health and safety. Participants should check with their doctor for advice if they are concerned about any pre-existing injuries or medical problems prior to hiking, climbing, caving, or ropes/challenge course activities.***

Medical Release

In the event of an emergency or non-emergency situation requiring medical treatment, I hereby grant permission for any and all medical and/or dental attention to myself or my child, in the event of an accidental injury or illness during participation with Rock Dimensions, until such time as I or the emergency contact can be reached. This permission includes but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel. Every reasonable effort will be made to contact the emergency contact person(s) listed on this form in the event that significant medical care is needed.

Participant signature ____________________________ Parent/Guardian signature _____________________