



MEDICAL FORM

PERSONAL INFORMATION

Participant's Name _____
Last First Middle

Date of Birth _____ Gender _____
month/day/year

Do you have any medical conditions? yes no If yes, explain: (please use the back if necessary)

Do you have allergies? (food, medicine, insects) yes no If yes, explain: (use the back if necessary)

Are you taking any medication? yes no If yes, explain: (please use the back if necessary)

Do you have any dietary restrictions? yes no If yes, explain: (please use the back if necessary)

EMERGENCY CONTACT

Name _____
Last First Relation

Phone (____) _____ (day) (____) _____ (evening)

ADDITIONAL INFORMATION

Medical Insurance Provider: (necessary for enrollment in trip)

Company Name Policy Number

Address Phone

Physician's Statement: _____ (participant's name) is in good health,
and should be able to fully participate in the vigorous activities associated with Rubicon Outdoors.

Physician's Signature _____ Date _____

I hereby authorize Rubicon Outdoors, acting by and through officers, agents or employees to administer and/or seek medical aid in the event of any accident, illness and/or injury and release said business and its agents directors, officers, and or employees from any liability resulting from the administration or seeking of such medical aid. I further authorize Rubicon Outdoors to give permission for hospital admittance and/or treatment in the event that I am unable to do so, and my parent, legal guardian or next of kin cannot be reached. I have medical insurance as here in after stated and-do-hereby agree to carry such insurance identification as is necessary for treatment in the event of injury or illness.

Participant's Signature _____ Date _____

Parent/Guardian's Signature _____ Date _____

(If applicant is under 18)