Great Leaps
Adventure CiC

# PRE ACTIVITY MEDICAL FORM

## All PARTICIPANTS TO COMPLETE AND RETURN

Name (BLOCK CAPITALS):

Age:

Contact Details:

Emergency Contact Details (If different):

**Medical Conditions:**

| | | |
|---|---|---|
| Heart Condition | Yes | No |
| High Blood Pressure | Yes | No |
| Diabetes | Yes | No |
| Asthma | Yes | No |
| Surgery within the last year | Yes | No |
| Joint Dislocation | Yes | No |
| Seizure Disorders | Yes | No |
| Broken Bones | Yes | No |
| Nose Bleeds | Yes | No |
| Stress | Yes | No |
| Chronic Headaches | Yes | No |
| Any chronic physical limitation (back, joints etc) | Yes | No |
| Have you been under a Doctors care in the past 12 months? | Yes | No |

If you have answered yes to any of the above, please provide details below:

**Allergies:**
Do you have any known allergies or have you ever suffered from a severe allergic reaction?

**Medication Information:**
Are you currently taking any prescription or non-prescription medications?

**Fitness Information:**

How would you identify your current fitness level. Poor Fair Good Excellent

Are you comfortable on or in the water? (Paddlesport Only) Yes No

Can you swim? (Paddlesport Only) Yes No

**Acknowledgement:**

Are you over the age of 18? Yes No

Name (Block Capitals): Date Completed:

Signature: Counter Signatory of Parent/Guardian (Under 18 only):

**Office Use Only:**

**CHECKED BY:** **Date:**