

CLIMBucknell MEDICAL FORM

Forrest D. Brown Conference Center at Cowan
Bucknell University, Lewisburg PA

PERSONAL INFORMATION

Name _____ Date of Birth _____

Address _____

Home Phone _____ Work Phone _____

Group/Organization _____ Date of Event _____

MEDICAL INFORMATION

Person Notified in an Emergency _____

Relationship _____ Home Phone _____ Work Phone _____

Family Physician _____ Phone _____

Address _____

Medical/Health Insurance Co. _____ Policy/ID No. _____

MEDICAL HISTORY

This section needs a response on each line. Write N/A if it does not apply.

Allergies _____

Current Medications _____

Conditions Requiring Medications _____

Recent Injuries, Illnesses, Operations _____

Corrective Lenses _____

Psychological or Behavioral Disorders _____

Conditions Preventing You from Participating in Activities _____

I certify that the medical/health insurance policy will remain in effect at the time of this activity. I also declare the statements on this form to be true.

SIGNATURE OF PARTICIPANT _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN _____