

UW-SUPERIOR HEALTH HISTORY QUESTIONNAIRE

Full Participant Name:		Event Name: Challenge Course and Indoor Climbing Wall		Event Dates	
Full Home Address:		Home Telephone Number:		Date of Birth: ____/____/____ Sex: M F	
				Height: Weight:	
*Parent/Guardian Name:		*Relationship:		Does participant have allergic reactions to: <input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No Other Antibiotics _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Other Medicine (type) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Insect Bites/Stings _____	
*Address (if different than above)		*Home Telephone Number:(if different than above)			
		*Parent/Guardian Work Telephone:			
Emergency contact in the event of an injury or illness. (Name, Relationship, Address, and Telephone Number) Physician: _____ Telephone: _____ Insurance Co.: _____ Policy No.: _____				Does participant take medication on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Identify _____	
				Has participant had or presently experiencing: <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Colitis <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Seizures/Blackouts <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Injury/Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Menstrual Difficulties <input type="checkbox"/> Yes <input type="checkbox"/> No Mental/Emotional Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Neck/Back Pain/Injury <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcer Other: _____	
Does the participant have any physical condition(s) requiring special considerations? Explain.					

*Required if participant is under the age of 18 years.