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:

*Address (if different than above)

*Home Telephone Number: (if different than above)

*Parent/Guardian Work Telephone:

Does participant have allergic reactions to:

❑ Yes ❑ No.....Penicillin
❑ Yes ❑ No.....Other Antibiotics _____
❑ Yes ❑ No.....Other Medicine (type) _____
❑ Yes ❑ No.....Insect Bites/Stings _____

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?

❑ Yes ❑ No If Yes, Identify _____

Has participant had or presently experiencing:

❑ Yes ❑ No Allergies
❑ Yes ❑ No Asthma
❑ Yes ❑ No Bleeding Disorder
❑ Yes ❑ No Cancer
❑ Yes ❑ No Colitis
❑ Yes ❑ No Diabetes
❑ Yes ❑ No Epilepsy/Seizures/Blackouts
❑ Yes ❑ No Heart Disease
❑ Yes ❑ No Hernia
❑ Yes ❑ No High Blood Pressure
❑ Yes ❑ No Joint Injury/Surgery
❑ Yes ❑ No Kidney Disease
❑ Yes ❑ No Menstrual Difficulties
❑ Yes ❑ No Mental/Emotional Problems
❑ Yes ❑ No Neck/Back Pain/Injury
❑ Yes ❑ No Rheumatic Fever
❑ Yes ❑ No Tuberculosis
❑ Yes ❑ 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.