MOUNTAIN SHADOW ADVENTURES
GUIDED ALPINE EXPERIENCES

Participant Health Information

Name (please print clearly): _____

D.O.B.:_____ Age: _____Cell Phone#:_____

Person to contact in case of an emergency:

Name:_____Cell Phone#:_____

Relationship: _____Other Phone #:_____

Do you have any allergies, particularly any that have previously resulted in an anaphylactic reaction, or that you suspect are capable of producing an anaphylactic reaction> (e.g., bee stings, iodine, drugs, food)?

Yes____ No_____

Please specify and include a brief description of reaction: *(Please note that if you answer "yes" to the above question, you must bring an epinephrine auto-injector and a back up auto-injector on your trip, and you must inform your guide of their storage location.)*

Are you regularly taking any medications?

Yes_____ No_____

Please list all medications & the condition they are for:

Do you have any chronic illnesses or conditions that might be expected to adversely impact you, your guide, or another participant on a climb (e.g., diabetes, asthma, epilepsy)?

Yes_____ No_____

Please specify and describe symptoms:

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Do you have any other physical conditions or disabilities that might limit your physical participation?

Yes_____ No_____

Please specify:

Have you had a tetanus shot within the past 10 years?

Yes____ No_____

Affirmation of Health and Authorization for Emergency Medical Care

I affirm that my health is good and that I am not under a physician's care for any condition that bears upon my fitness to participate in the activities, including heart or lung conditions, severe allergies or other conditions that may limit my ability to participate in physically strenuous outdoor activities where immediate medical care may not be possible. I affirm that I will provide all such information to Mountain Shadow Adventures, LLC staff. I hereby give permission for the staff of Mountain Shadow Adventures, LLC to render to me or seek for me first aid or emergency medical treatment in the event of injury or illness during the activity, including transportation by ambulance and hospitalization. I will be responsible for any and all costs of medical attention and treatment.

_____ _____

Signature of Participant (or Parent/Guardian if under 18yrs old) Date

If signing on behalf of a minor, printed full name of minor

Participant:

_____