Eglin AFB Outdoor Adventure
Medical Information

Please answer all of these questions truthfully and to the best of your knowledge. All information will be kept confidential.

_____ _____
Print Your Name Date of Birth

_____
Height/ Weight

* Please list below any allergies you may have to certain foods, medications, insect bites or stings, pollen, etc.

_____
_____

* Please list below any medication or drugs, either prescribed or not, that you are currently taking or will be taking prior to or during the activity.

_____
_____

* Please list any ailments, injuries, or physical disabilities that would limit your ability to participate in the Outdoor Adventure Program activity.

_____
_____

*Has your physician been notified of your participation in this activity? Yes_____ No_____

*Emergency Contact Information:
Name:_____ Phone:_____
Address:_____

Thank you for your cooperation. This questionnaire must be returned to the Eglin Outdoor Adventure Program prior to the start date of the activity.

_____ _____
Signature Date

_____ _____
Signature of parent or legal guardian Date
(if participant is under 18 years old)

***Eglin AFB Outdoor Recreation reserves the right to deny participation to any individual we feel is not physically qualified for this event.**