ALPINE ENDEAVORS Mohonk Mountain House

HEALTH HISTORY

NAME _____ ROOM # _____ DATE: _____

WE REQUIRE FULL DISCLOSURE OF YOUR CURRENT HEALTH. THE INFORMATION YOU PROVIDE MAY ASSIST PEOPLE IN THE UNLIKELY EVENT OF AN ACCIDENT. THEREFORE, BEFORE YOU FILL THIS FORM OUT, PLEASE READ IT CAREFULLY; FULL AND ACCURATE COMPLETION OF ALL SECTIONS IS VERY IMPORTANT.

Gender: M or F Age: ____ years. Birthdate: _____

Height: _____ Weight: _____ lbs

Home Address: _____ City: _____ ST: _____ Zip Code: _____

Home Phone: _____

Email Address _____

Cell Phone: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Physician: _____ Phone: _____

PLEASE LIST ALL INFORMATION REGARDING THE FOLLOWING:

Allergies
(please include side affects): _____

Disabilities: _____

Heart Conditions: _____

Phobias or Fears: _____

Past Injuries or Illnesses: _____

Past Operations: _____

Current Medications: _____
(include why used,
and any side affects) _____

Can you swim? _____ Level of ability: _____ First Aid Training? _____

Do you smoke? _____ Do you wear glasses/contact lenses? _____ Do you have dentures/false teeth? _____

_____

EQUIPMENT BORROWED:
Rock shoe /size: _____ Helmet: _____ Harness/size: _____ Chalk Bag: _____ Pack/model: _____

Other: _____