Saint Mary's University of Minnesota
Informed Consent / Medical History
Challenge Ropes Course Program

(Saint Mary's University of Minnesota ("the University") reserves the right to deny any person or group participation at any time, based on equipment, behavior, and medical conditions.)

Saint Mary's University of Minnesota requires that every participant provide certain health/medical information to the instructor(s) so that they are prepared to help participants make informed choices about their level of participation. The following information will be held in confidence. Please complete the form prior to signing the Participant Agreement, Release and Consent for Emergency Treatment and return both forms to the Saint Mary's University of Minnesota's Outdoor Leadership Office prior to participating in any activities.

PARTICIPANT INFORMATION
Date(s) of Program(s):_____

Full Name: _____ Sex _____ Date of Birth _____/_____/_____

Insurance Company_____

MEDICAL INFORMATION:

1. Do you have any pre-existing injuries that might be aggravated by participating? Yes No
2. Are you currently taking any medication (prescribed or otherwise)? Yes No
3. Do you have any physical or health conditions that will limit participation? Yes No
4. Do you have any allergies or reactions to medications? Yes No
5. Do you have any of the following symptoms/conditions?
   - A. Do you have any history of heart disease or heart attack? Yes No
   - B. Do you have high blood pressure or any history of high blood pressure? Yes No
   - C. Do you have a history of any chest pains/pressure heart palpations, heart murmurs? Yes No
   - D. Have you ever had a stroke? Yes No
   - E. Do you have diabetes? Yes No
   - F. Are you currently pregnant? Yes No
   - G. Do you have a history of seizures or convulsions? Yes No

   If you circled "yes" to any of items A through G, you must have the approval of your physician to participate.
   I certify that the Participant is physically able to participate in the SMU Challenge Ropes Course.
   _____Date_____ _____
   Physician's Signature Physician's Printed Name & Phone Number
6. If you circled "yes" to any of the questions above, please identify the condition and describe it below.

_____
_____
_____

Please add any additional information that you feel may be relevant: _____
_____
_____

_____ **Date:_____**
Participant Signature (Minors must sign)

_____ **Date:_____**
Parent/Guardian/Legal Representative Signature **Relationship**
(Required if Participant is under 18 years of age)

_____
IN CASE OF EMERGENCY CONTACT/PHONE RELATIONSHIP

_____
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