

The Spot Bouldering Gym

Participant Medical Information Form

Name: _____ Age: _____

Phone: _____ Height: _____

Address: _____ Weight: _____

Emergency contact: _____

Climbing days can be very physically challenging. Often they are more rigorous than participants are used to and expecting. If you are unsure of your level of fitness or health please discuss this with your doctor and speak with a Spot representative about your particular course. I understand that climbing can be dangerous and that there are inherent risks in outdoor climbing, and have read and signed The Spot's release.

Please Initial _____

General Fitness level: circle one 1 2 3 4 5 (1=inactive / poor fitness , 5=very active / fit)

Experience climbing: circle one 1 2 3 4 5 (1=never climbed, 3=climb occasionally, 5=climb a lot)

Are you seeing a doctor for any reason?

Are you taking any medications? (Please take your regular medication dosages on climbing days)

Please check if you have ever suffered from any of the following:

Please explain any answers that have been checked

Allergic to insect bites: _____

Allergic to foods: What foods: _____

Epilepsy: _____

Taking any medications: _____

HIV/AIDS: _____

Hypothermia: _____

Frostbite: _____

High Blood pressure: _____

AMS-(altitude sickness): _____

Back Problems: _____

Recent Injuries: _____

Diabetes:
(treated with diet or insulin?) _____

Asthma: _____

Heart Problems: _____

Do you have a medical condition, injury or illness not listed above? _____

I _____, hereby acknowledge and understand that The Spot Bouldering Gym, LLC and its agents are under no duty to provide any first aid or medical treatment in any event, according to their sole discretion. Additionally, I hereby consent to any first aid care, hospital care, and/or medical/surgical care which The Spot Bouldering Gym, LLC and its agents deem appropriate or necessary, if I am not able at the time to give my written consent due to unconsciousness, or other mental incapacity.

Signature: _____ Date: _____