

CONFIDENTIAL MEDICAL REVIEW
For use with Venture High Team Challenge Programs

Purpose: With the combination of your knowledge of yourself and the Venture Program's knowledge of the High Course Program, we can better provide a productive and fun day. The information is requested below for the following purposes:

1. It serves as a helpful reminder to you of physical precautions and care you may need to take because of previous injuries or other physical conditions you may have.
2. In case of emergencies, it provides us with accurate information about you so that we can provide and/or seek appropriate treatment. You are accountable for providing an accurate medical history.
3. It is intended to help you determine whether participation in some or all of the High Course Program is appropriate. **The Venture Program can assist you with this determination, but the final determination about whether to participate is your responsibility.** Please feel free to discuss any concerns you may have about the program with the Venture staff.

This information is considered highly confidential. **All content found herein will not become public without your consent.**

<i>Please print or type</i>	Program Date:
Name:	Home Phone:
Home Address:	City/State/Zip:
Emergency Contact:	Emergency Phone:
Doctor:	Doctor's Phone:

Participation in this program is voluntary, and you can decline participation in all of, or any part of, the activities occurring during the program.

The information requested below is not intended to address every medical issue you may have, nor is it intended to ensure your safe participation in the program, but it is intended to highlight some common medical issues that may affect your participation in the High Course Program. If you have any medical issue that is not requested below, but of which you think it is important that the Venture Program be aware, please include that information below.

Please answer all of the questions. If you answer yes to any of the following questions, please explain, naming the condition and giving a detailed description, including dates and restrictions, if any. Use back and/or additional paper if needed.

1. Have you been told by a physician that you have, or are you aware of having, any medical conditions that could be aggravated by physical activity, such as heart disease, high blood pressure, lung disease, diabetes, pregnancy or others?

- Yes
 No

2. Have you been told by a physician that you have, or are you aware of having, any problems with your neck, back, shoulders, wrists, hips, ankles or knees that may be aggravated by physical activity?

- Yes
 No

3. Have you been told by a physician that you have, or are you aware of having, any other medical, physical or psychological problems you think we should know about before the activities begin (i.e. asthma, allergies to bee stings, food, etc., are you on any medications, etc.)?

- Yes
 No

Signature: _____ Date: _____