

PHOENIX MULTISPORT DISCLOSURE AND MEDICAL INFORMATION FORM (DMIF)

Disclosure:

Phoenix Multisport's (PM) programming involves a variety rigorous physical outdoor managed risk activities. (The level of participation in a PM activity is at all times completely up to the individual's choice.) There are differing levels of risks in these activities, which must be assumed by each participant. An individual may suffer an emotional or physical injury or disability.

By signing this form and participating in the PM activities, you and your parent/legal guardian agree, with the intent to be legally bound by your agreement, to release PM from any and all causes of action for injury, property damage, or any other type of liability claim whatsoever. You also agree that you have answered all of the questions on this form truthfully and that PM staff and its employees can rely on those answers.

PM policy for participation in all activities requires that the participant's health and accident insurance provide their primary coverage. PM reserves the right to refuse services to those persons not covered by health and accident insurance and/or to those persons who present an unreasonable risk to themselves or others when engaging in activity(ies).

Certain health and medical information must be made known to the PM instructors conducting the program prior to the start of risk activities. This information is used exclusively to help with preparations to respond appropriately if the need arises, and is not made available for other purposes.

Please complete fully the form below and on the back of this page. Return the completed form to the PM Event Leader prior to participation.

Name: _____ Date of Birth: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone _____ Cell Home Work E-mail Address: _____

Secondary Phone _____ Cell Home Work _____

Emergency Contact Name: _____ Phone: _____

Relationship: Parent Sibling Spouse / Significant Other Friend Organization/Professional

Injuries - Please list all physical disabilities, handicaps, chronic joint conditions (temporary or permanent), back injuries, pain, or chronic back problems, and all current and historical musculoskeletal problems (breaks, fractures, sprains, strains, etc).

Injury	Date of Injury	Medications	Limitations/Precautions
1.			<input type="checkbox"/> None
2.			<input type="checkbox"/> None
3.			<input type="checkbox"/> None
4.			<input type="checkbox"/> None

Notes:

Medical and Mental Health Conditions - Please list all physical and mental health conditions, noting any associated medications and limitations. Please include if you have ever had asthma, diabetes, thyroid trouble, bleeding problems, epilepsy, seizures, hypertension, elevated cholesterol or triglycerides, history of chest pain with exertion, cardiac condition(s), or any type of arthritis.

Condition	Date of Condition	Medications/Dosage	Limitations//Precautions
1.			<input type="checkbox"/> None
2.			<input type="checkbox"/> None
3.			<input type="checkbox"/> None
4.			<input type="checkbox"/> None

Notes:

Allergies - Please list all allergies including those to medications (e.g. penicillin, aspirin, sulfa drugs), foods (e.g. milk, seafood, peanuts), insect bites (e.g. bees, wasps, spiders), or other environmental substances (e.g. dust, ragweed, poison ivy)?

Allergy	Date Last Reaction	Last Reaction What happened?	Last Reaction Treatment Received	Limitations/Precautions
1.				<input type="checkbox"/> None
2.				<input type="checkbox"/> None
3.				<input type="checkbox"/> None

Drug/Alcohol Withdrawal- Have you experienced any withdrawal symptoms experienced in the time periods listed below. This may include anxiety, seizures, shakes, DTs, hallucinations, heart irregularities, insomnia, etc.

Notes:

- In the last 48 hours Yes No Maybe
- In the last 6 months Yes No Maybe

Dietary Restrictions- Please note any special dietary restrictions: _____

I have read the enclosed information and understand the physical and stressful nature of the PM Programming. I have registered any medical or physical conditions that might affect my ability to participate in any activity or safely receive medical attention in the event of an emergency. As a participant, I will at all times wear any required equipment, and follow the directions of the facilitators and instructors.

Permission is granted by those signed below for any emergency medical care, anesthesia, and/or surgical procedures, which might become necessary.

Participant Signature: _____ Date: _____ Staff Witness: _____ Date: _____