



**MOUNT ST. HELENS
INSTITUTE**

Medical Release Form

Participant's Name: _____ Birth Date: _____ Age: ____ Gender: ____

Parent/Guardian Name: _____ (If participant is under the age of 18)

Address: _____ City: _____ Zip Code: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Primary Doctor: _____ Phone: (____) _____

Insurance Company Name: _____ Group/Policy Number: _____

In the unlikely event of an emergency please list in order of preference the party we should contact. Please list name and relation:

1) _____ Phone Day:(____) _____

Evening: (____) _____

2) _____ Phone Day: (____) _____

Evening: (____) _____

Allergies – Food, Medical, and Natural:

List all possible Reactions:

Please list all current medications you are on and for what reason:

Do you have any history of joint dislocations, broken bones, skeletal surgeries, fainting, breathing complications, cardiovascular issues, or other relevant medical history that could affect your ability to climb, or be pertinent in a medical emergency?

____ Yes ____ No (If yes please explain)

Please Read: (Please initial acknowledging each statement)

_____ I hereby certify that I, _____, am in normal health and capable of safe participation in the program and/or activities in which I am enrolling/registering.

_____ I recognize that participants must follow safety instructions, remain in areas designated by staff and refrain from behavior that is harmful to one self or others.

_____ I am aware that I may have an opportunity to participate in and I understand that I could be involved in activities involving a degree of risk that could be potentially hazardous to my health. This includes all programs and activities registered under the Mount St. Helens Institute. I hereby release Mount St. Helens Institute from any and all responsibility and liability of any nature resulting from my participation in Mount St. Helens Institute activities and programs. I understand it is my responsibility to provide my own accident and health insurance while participating in all Mount St. Helens Institute activities and programs and that Mount St. Helens Institute does not provide any health or accident coverage for its participants.

_____ I further give my permission to be given emergency medical treatment by a qualified Mount St. Helens Institute staff until emergency contacts can be reached and be present and/or emergency care arrives for treatment. In case of an emergency, I understand that I will be transported to an appropriate medical facility by the local emergency unit for treatment if the local emergency resources deem it necessary. In the event that emergency contacts listed above cannot be contacted, I further consent to the medical, surgical and hospital care to be performed for myself by a licensed physician, or hospital when deemed immediately necessary by the physician to safeguard my health. It is understood that in some medical situations, the staff will need to contact the local emergency resources before the emergency contacts (listed above), or primary physician (listed above) is contacted.

Participant Name: _____

Participant Signature: _____ Date: ___/___/___

***Parent/Guardian must sign if participant is under the age of 18. Please print name, sign, and fill in date of completion.**

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date ___/___/___