

Last Name: \_\_\_\_\_

Session Date: \_\_\_\_\_

The Center for Experiential  
Leadership Training at Lehigh University



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## LEHIGH UNIVERSITY ROPES CHALLENGE COURSE Medical Information Form

Please complete this form before arriving for your Ropes Challenge Course Session. The medical information that you are providing will be kept confidential. It will not be released to anyone without your permission, except in an emergency where you are unable to otherwise communicate your wishes.

### PERSONAL INFORMATION

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Last Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Organization: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

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In case of emergency, please provide contact information for who we should notify.

Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

### MEDICAL INFORMATION

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Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Medical/Health Insurance Co.: \_\_\_\_\_ Policy/ID Number: \_\_\_\_\_

### SIGNATURE(S)

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I certify that the above information is correct and that the medical/health insurance policy listed above will remain in full force and effect at the time of my participation in the Lehigh University Ropes Challenge Course.

\_\_\_\_\_  
*Signature of Participant*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Parent/Guardian  
(if participant is under 18 years of age)*

\_\_\_\_\_  
*Date*