



# McMASTER OUTDOOR RECREATION



## **Altitude Team Development & Leadership Program** **Medical Screening Form:**

Due to the nature and location of the ALTITUDE Team Development & Leadership Program, all participants are required to provide accurate health and medical information prior to participation.

The information gathered on this form is collected under the authority of the McMaster University Act, 1976. The information is used for the purpose of administering the Department of Athletics and Recreation Outdoor Recreation Programs and, on occasion, for statistical purposes. Personal information provided on this form will not be used for any unrelated purpose without prior consent. This information is protected and is being collected pursuant to section 39(2) and section 42 of the Freedom of Information and Protection of Privacy Act of Ontario (RSO 1990). Questions regarding the collection or use of this personal information should be directed to the Director, Athletics and Recreations, David Braley Athletic Center, Room W127.

### **Participant Information:**

Group Name: \_\_\_\_\_

Date(s) of Program: \_\_\_\_\_

Name of Participant: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone # (Home): \_\_\_\_\_

Email Address: \_\_\_\_\_

### *Emergency Contact Information:*

Contact Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone # (Daytime): \_\_\_\_\_

(Evening) \_\_\_\_\_

### **Participant Medication/Allergy Information:**

Please list any medications you are currently on, along with their purpose.

(e.g. Diovan for High Blood Pressure, Celexa for Depression/Anxiety)

**Medication**

**Purpose**

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**NOTE – FORM CONTINUED ON REVERSE SIDE**



Achieving Leadership Through Integrating Teamwork, Unity, Dedication, and Empowerment



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Please list any allergic reactions to medications, food or environmental factors:

| Allergy | Reaction | Treatment | Epipen Required?         |                          |
|---------|----------|-----------|--------------------------|--------------------------|
|         |          |           | Yes                      | No                       |
| _____   | _____    | _____     | <input type="checkbox"/> | <input type="checkbox"/> |
| _____   | _____    | _____     | <input type="checkbox"/> | <input type="checkbox"/> |
| _____   | _____    | _____     | <input type="checkbox"/> | <input type="checkbox"/> |
| _____   | _____    | _____     | <input type="checkbox"/> | <input type="checkbox"/> |
| _____   | _____    | _____     | <input type="checkbox"/> | <input type="checkbox"/> |

Note: Please remember to bring your own Epipen(s) if required.

### Medical Screening Form – Continued:

For most of the time, you will be undertaking activities which are best described as “**moderate exertion**” (normal walking, raking leaves, or waiting tables). Some situations may require you to momentarily engage in “**vigorous exertion**” (slow jogging, speed-walking, or fast biking).

If these types of activities are difficult for you, we strongly advise you to discuss your participation in the course with a physician who knows your health history. If these are activities in which you regularly engage without difficulty, you should be fit for participation.

Finally, there are a few specific medical conditions about which participants should always seek advice from their physicians before engaging in challenge course and climbing activities. Please consult with a physician prior to participation if you are **pregnant**, have had a **kidney or liver transplant**, are **healing a fracture or joint injury**, have had **recent surgery**, or have **Down Syndrome**. If you or your physician have any questions regarding these conditions or about the challenge course and climbing activities, feel free to contact us at 905-525-9140 ext. 26384.

I have reviewed this material, and have consulted with my physician if appropriate. I believe that I am fit to participate in the challenge course. I understand that I am not required to complete any event, and am free to modify my participation at any time.

Participant Name: \_\_\_\_\_

Participant Signature: \_\_\_\_\_

Date \_\_\_\_\_

#### **Authorization For Seeking Treatment of Minors:**

In the event of accident or apparent illness, I irrevocably authorize ALTITUDE staff to secure emergency medical services and treatment for this participant if, in their judgment, such services or treatments are necessary. I understand that in the event of a medical emergency every effort will be made to contact parents or guardians.

Parent/Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_

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





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## Altitude Team Development & Leadership Program

### Participant Consent Form

Participant Name: \_\_\_\_\_

I hereby acknowledge that certain risks of injury are inherent to participation in recreational activities, sporting activities and lessons on and associated with the ALTITUDE Program. These types of injuries may be minor or serious and may result from one's actions, or the actions or inactions of others or a combination of both.

I hereby understand that certain activities require a minimum level of fitness and health (physical, mental, and emotional) and that each person has a different capacity for participating in these activities. Some activities involve an intense level of activity.

I hereby agree that McMaster University, its faculty, staff and agents shall not be liable for any injury, loss or damage to person or property, incurred during this program, including deterioration of health or illness or aggravation of condition resulting from participation in these activities, property damage or lost property.

I have read thoroughly the information brochure and understand the intensity of all activities involved. I understand that the level of my participation is on a *Challenge by Choice* basis and that all McMaster University faculty, staff, and agents will respect my decision regarding the level of intensity of my participation.

If at any time emergency medical treatment is necessary, I give my consent for treatment to be given. Every effort will be made to contact parent/guardian(s) and or emergency contacts. McMaster University may decline a participant due to physical and/or verbal abuse towards staff and participants.

I hereby authorize McMaster University to take my photograph to display and otherwise use these photographs without charge solely for the purpose of promotional material in connection with Department of Athletics & Recreation Camps & Programs.

I declare having read and understood the above informed consent agreement in its entirety.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian (if under the age of 18)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

