

Uprising Adventure Guides, Inc.
Medical Release Form

Participants Name: _____

Home Street Address: _____

City/State/Zip: _____ Email: _____

Phone:(____) _____ Birth date: ____/____/____ Age: ____ Sex: ____

Emergency Contact:

Name: _____ Relationship
to Participant: _____

Home Phone:(____) _____ Work Phone:(____) _____

Do you have any Medical Conditions? YES NO If so explain: _____

Do you have any Allergies? YES NO If so explain: _____

Are you taking any prescription or non-prescription Medication? YES NO

If so explain: _____

Do you have any dietary restrictions or needs? YES NO If so explain: _____

Do you carry Medical Insurance? YES NO

Medical Insurance company or Provider: _____

Describe your current activity and fitness level _____

Signature _____ Date _____