



**MEDICAL FORM OVER-18**

CTTE Confidential Personal and Medical Information

This form is to be completed by any adult taking part in a CTTE group activity session. The medical information on this form will not be kept once the event has finished. Please complete the following:

Name: ..... Organisation:.....

Job Title: ..... Email:.....

Home Address:

.....  
.....

Post Code.....

Home Telephone: ..... Mobile Telephone:.....

Date of Birth: ..... Sex (please circle): Male/ Female

Contact in case of an emergency:

.....

Contact's phone: ..... Contacts Mobile: .....

Relationship of contact.....

Weight (Kg's): .....

Medical Form - Please circle YES or NO to all of the following. :

COMMENT IF YES

Have you ever had or do you currently have:

Heart problems of any kind? Yes / No

High blood pressure? Yes / No

Recurrent back problems or surgery? Yes / No

Epilepsy, seizures, convulsions or medications to prevent them? Yes / No

Asthma, wheezing with breathing or wheezing with exercise? Yes / No

Diabetes? Yes / No

Any arm or leg problems? Yes / No

Do you regularly take prescription or non-prescription medications (excluding contraception pills)? Yes / No

Women: Are you pregnant? Yes / No

Are there any other medical conditions that you think we should be aware of?

Acknowledgement of risk: There will always be some risk involved in any type of adventurous activity, and indeed the benefits of the activity would probably be nullified if these risks were completely removed. The type of risk is generally confined to the same sort of risks that a normal adult involved in normal active recreation may experience. We consider the level of risk to be low and reasonable. However, you must decide if you also consider it reasonable. Our 'Challenge by Choice' approach endeavours to ensure that participation in any activity is always at your own discretion. The above declaration does not absolve Closer to the Edge of its "Duty of Care" and other legal responsibilities.

I have read and understand the above statement. The information I have provided about my medical history is accurate to the best of my knowledge.

Signature of participant: .....

PRINT NAME:

Date: .....

For instructors use only.....Signature following review.