

**North Peninsula Recreation**  
**Consent To Treat**

This is to certify that on this date, I \_\_\_\_\_ give my consent to North Peninsula Recreation S.A. and its medical representatives to obtain medical care from any licensed physician, hospital, or clinic for the above mentioned participant, for any injury that could arise from participation in the scheduled activity or event.

If said athlete is covered by any insurance company, please complete the following:

Name of Carrier: \_\_\_\_\_

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

Policy Number: \_\_\_\_\_

**\*\*Signed:** \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_

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

Emergency Phone: \_\_\_\_\_

**North Peninsula Recreation does not provide insurance for this activity or event. You participate in this activity at your own expense, with or without insurance.**

**Medical History Form**

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

Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

**Who To Contact In Case Of An Emergency?**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

Hospital of Choice: \_\_\_\_\_

**Please Complete The Following:**

If the answer to any of the following questions is or was yes, please describe the problem and its implications for the proper first aid treatment. Have you had (or do you presently have) any of the following?

Head injury (concussion, skull fracture)	Yes	No
Fainting spells	Yes	No
Convulsions/epilepsy	Yes	No
Neck or back injury	Yes	No
Asthma	Yes	No
High Blood Pressure	Yes	No
Kidney problems	Yes	No
Hernia	Yes	No
Diabetes	Yes	No
Heart murmur	Yes	No
Allergies	Yes	No

Specify: \_\_\_\_\_

Injuries to:

Shoulder	Yes	No
Knee	Yes	No
Ankle	Yes	No
Fingers	Yes	No
Arm	Yes	No
Other	Yes	No

Impaired vision \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

Impaired hearing \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

Other: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

Are you currently taking any medications? \_\_\_\_\_ What? \_\_\_\_\_ Why? \_\_\_\_\_

Has the doctor placed any restrictions on your activity? \_\_\_\_\_

**Participant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_