

RYLA 2021 HEALTH STATEMENT FORM

The proposed activity provided by RYLA at Lake Placid Camp and Conference Center requires participation in physical exercises, which are, by their nature, physically demanding. Many of the activities will challenge you causing surges in blood pressure and pulse rates. It is imperative that you are free of any heart related or other diseases. Therefore, all participants must be free of medical or physical conditions that might create undue risks to themselves or any others that depend on them. Good physical condition will increase your enjoyment of outdoor activities. If there is any doubt about your ability to safely participate in this experience, you should consult a physician for a complete examination.

Please fill this form out to the best of your knowledge.

Name: _____ Birth Date: _____
Address: _____ Gender: _____
City, State, Zip: _____ Phone _____
Name of Physician: _____ Date of last physical: _____
In case of emergency notify _____ Relationship: _____
Home Address: _____ Phone: _____
City, State, Zip: _____ Work Phone: _____

Health History (Circle the appropriate answer and describe any YES answers)

1. Do you carry family health and accident insurance? Yes No
Carrier: _____ Policy #: _____
2. General Health Statement: I am in EXCELLENT GOOD FAIR POOR health. (Circle one)
3. Have you had or do you currently have any heart problems (dates). Yes No If YES, dates: _____
4. Do you frequently suffer from pains in your chest? Yes No
5. Do you often feel faint or have spells of severe dizziness? Yes No
6. Has a doctor ever told you that you have high blood pressure? Yes No
7. Do you have arthritis, joint or back problems that might be aggravated by exercise? Yes No
8. Have you had any operations, organ transplants, or serious injuries? Yes No If YES, dates: _____
9. Do you have any disabilities or chronic recurring illness? Yes No
10. Are there any activities to be limited/discouraged on advice of your physician? Yes No
11. Are you allergic to any medications, insects or pollen? Yes No
If YES, do you have an EpiPen? Yes No
12. Do you have Epilepsy? Yes No
13. Do you have Diabetes? Yes No
14. Do you have any prescribed meal plan or dietary restrictions? Yes No
If YES, describe _____
15. Are you currently sick and/or using medication that is not listed above? Yes No
If YES, describe _____

Signature of Participant: _____ Date: _____

Signature of Parent/Guardian _____ Date: _____