

CAVEMAN ZIPLINE HEALTH STATEMENT

The proposed activity provided by **Caveman Zipline, LLC** requires participation in physical exercises which are, by their nature, physically demanding. Many of the activities will challenge you, and cause surges in blood pressure and pulse rates. It is imperative that you are free of any heart or any other diseases. Therefore, all participants must be free of medical or physical conditions which might create undue risks to themselves or any other who depend on them. Good physical condition will increase your enjoyment of the outdoor activities. If there is any doubt about your ability to safely participate in this experience, you should have a physical examination.

NAME: _____ BIRTH DATE: _____

ADDRESS: _____ GENDER: _____

CITY, STATE, ZIP: _____ AGE: _____

WORK PHONE: _____ HOME PHONE: _____

NAME OF PHYSICIAN: _____ DATE OF LAST PHYSICAL EXAM: _____

IN CASE OF EMERGENCY NOTIFY: _____

HOME ADDRESS: _____ HOME PHONE: _____

CITY, STATE, ZIP: _____ WORK PHONE: _____

HEALTH HISTORY: (Circle the appropriate answers and describe any YES answers.)

CIRCLE YES or NO

HAVE YOU OR DO YOU CURRENTLY HAVE ANY HEART PROBLEMS

(DATES) _____

Yes No

DO YOU FREQUENTLY SUFFER FROM PAINS IN YOUR CHEST: _____

Yes No

DO YOU OFTEN FEEL FAINT OR HAVE SPELLS OF SEVERE DIZZINESS: _____

Yes No

HAS YOUR DOCTOR EVER TOLD YOU THAT YOU HAVE HIGH BLOOD PRESSURE: _____

Yes No

ARE YOU A SMOKER: _____

Yes No

(NOTE: If you have had any heart related problems you will need to have a release form from a physician)

ARE YOU PREGNANT OR THINK YOU POSSIBLY COULD BE PREGNANT? _____

Yes No

DO YOU HAVE ARTHRITIS, JOINT, OR BACK PROBLEMS THAT MIGHT BE AGGRAVATED BY EXERCISE: _____

Yes No

Yes No

HAVE YOU HAD ANY OPERATIONS OR SERIOUS INJURIES (DATES): _____

Yes No

DO YOU HAVE A BELLY BUTTON PIERCING OR OTHER BODY PIERCINGS? (Piercings should be removed)

Yes No

DO YOU HAVE DISABILITIES OR CHRONIC RECURRING ILLNESS: _____

Yes No

ARE THERE ANY ACTIVITIES TO BE LIMITED/DISCOURAGES BY PHYSICIANS ADVICE: _____

Yes No

ARE YOU ALLERGIC TO ANY MEDICINES, INSECTS OR POLLEN: _____

Yes No

DO YOU HAVE EPILEPSY: _____

Yes No

DO YOU HAVE DIABETES: _____

Yes No

Have you ever had a panic attack or suffer from any type of mental disorder? _____

Yes No

ARE YOU CURRENTLY SICK AND/OR USING A MEDICATION THAT'S NOT LIST ABOVE: _____

Yes No

DO YOU CARRY FAMILY MEDICAL/HOSPITAL INSURANCE: _____

Yes No

CARRIER: _____ POLICY NUMBER: _____

SUGGESTIONS ON HEALTH RELATED INFORMATION FOR CZ PERSONNEL: _____

GENERAL HEALTH STATEMENT: _____

REPRESENTATION AND EMERGENCY AUTHORIZATION

*This health history is correct so far as I know, and I believe that my health is satisfactory to participate in challenge course activities. I also agree to allow my picture or my image to be used by **Caveman Zipline, LLC**.*

*I hereby give permission to the medical personnel selected by **Caveman Zipline, LLC** to order injection and/or anesthesia and/or surgery for me. Such authorization for emergency treatment shall include, but not limited to, charges incurred for the providing of aid and arranging evacuation if **Caveman Zipline LLC**, or its agents, determine that such evacuation is necessary or desirable. I further agree to assume responsibility for the costs of any specialized means of evacuation and of any medical care and acknowledge that these costs are the financial responsibility of the undersigned. I also understand and agree by any restrictions placed on my activities.*

Participant understands that **Caveman Zipline, LLC cannot control weather and takes no responsibility for weather related accidents. Participant understands they must be in good health, no recent surgeries-procedures, and CANNOT be pregnant. There are 150 stairs on the course that the participant must be able to climb on their own. Participant cannot exceed 270 pounds. Participant agrees not to go upside down on course and not to let go of yellow lanyard unless braking or self-rescuing (guide instructed releases). Guides retain the right to refuse service to any participant who cannot pass the instructions and physical activity at the training school.*

SIGNATURE OF PARTICIPANT: _____ DATE: _____

WITNESS: _____ DATE: _____