RYLA 2024 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 your 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: ______________________