

**RYLA 2022 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: \_\_\_\_\_