



## Avalanche Course Medical Form

This questionnaire is a component of the AIARE risk management plan. Medical information provided in this form will help your instructors provide the appropriate response should a medical emergency occur during your course. All medical information will be kept confidential. Any change in your medical/physical condition after returning this form must be communicated to your AIARE course instructor(s). Failure to disclose all information could result in harm to yourself and your fellow students, or dismissal from the course.

**This form must be signed by hand. Please print this form after filling it out electronically and sign at the bottom of the next page.**

### Part I. General Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age at Course Start \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_

### Part II. Medical History and Information

**Please Note: Students are responsible for any medical expenses and should be covered by their own medical insurance.**

Describe your current fitness level (type of physical activities you engage in and their frequency)

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Consider [AIARE's Participant Risk Acknowledgment Form](#) and state any medical conditions which may affect your ability to participate fully in the course.

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Are you currently under the care of a physician or medical practitioner of any kind?

If "YES," please explain.

Yes  No

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Do you have any allergies?

If "YES," what are you allergic to (medications, insects, foods, etc.) and how serious is your reaction?

Yes  No

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Do you expect to be using medication of any kind at the time of your course (prescription or over-the-counter)?

If "YES", specify the medication, dosage, condition for which it is used, and current side effects:

Yes  No

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**Part III. Signatures Required (To be completed by parent/guardian if student is under 18)**

By the signature(s) below, consent is hereby given for the student to participate on a American Institute for Avalanche Research and Education (AIARE) course, and permission is given for any emergency medical treatment which may become necessary, including first aid by certified course instructors; search and rescue operations, and evacuation; emergency hospitalization, operation, surgery, anesthesia, or other treatment which may become necessary. Your signature(s) below also provide(s) agreement that you are responsible for any costs incurred for the above events.

I confirm that the information provided above is a complete and accurate statement of the physical and medical factors which may affect my participation on an AIARE course. I realize that failure to disclose such information could result in harm to myself and fellow participants, or dismissal from the course. I agree to notify my course instructor(s) should there be any change in my health or physical condition prior to or during the course.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Parent or Guardian** (if student is under 18): By your signature below, you confirm that you have read all of this medical form and that the information supplied by both the student and you is complete and accurate. You also give your permission for the student to participate on a American Institute for Avalanche Research and Education (AIARE) course for which he/she has registered, and you give your permission for any emergency medical treatment which may become necessary, including first aid by certified course instructors, search and rescue operations, and evacuation; emergency hospitalization, operation, surgery, anesthesia, or other treatment which may become necessary. Your signature below also provide(s) agreement that you are responsible for any costs incurred for the above events.

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_