AMERICAN HERITAGE GIRLS®
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High Adventure Activity Medical Form

- Girl and Adult Members who will be participating in Authorized High Adventure Activities are required to complete a new *High Adventure Activity Medical Form* each year.
- The form requires a health examination from a licensed health care provider.
- These forms are kept on file at the Troop level.
- The high adventure classification is based on a number of risk factors including but not limited to the physical exertion, potential for injury, potential severity of an injury, recommended supervision of the activity, equipment used in the activity that could fail, and prior accidents and injuries for the activity.

Licensed health care provider: You are being asked to certify that this individual has no contraindications for participation in the following activities: Bouldering (Indoor and Outdoor), High Ropes and Challenge Courses, Giant Swings and Zip lining (activities utilizing harnesses), Horseback Riding (on trails or in a ring), Rappelling (Indoor and Outdoor), Rock Climbing (Indoor and Outdoor), Shooting Sports (paintball, BB guns, CO2 Pellet Rifles, Rifle and Shotgun, Spelunking, Ice Fishing, Winter Sports and Activities (skiing, snowboarding and snowshoeing), Canoeing, Kayaking, Pedal Boating, Row Boating, Sail Boating, SCUBA Diving and Snorkeling, Stand-Up Paddle Boarding, Surfing, Tubing, Waterskiing, Wakeboarding and Kneeboarding, Whitewater Activities. Please complete the sections below.

Member Name			
Troop Number			
Date of birth		Age	
Weight		Height	
Blood Pressure		Pulse	
	Normal	Abnormal	Explain
Eyes			
Ear/nose/throat			
Lungs			
Heart			
Abdomen			
Musculoskeletal			
Neurological			
Other			

I certify that I have reviewed the health history and examined this individual and find no contraindications for participation in AHG Authorized High Adventure Activities. This participant: (1) Does not have uncontrolled or poorly controlled heart disease, asthma, hypertension, or diabetes. (2) Has not had orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months. Or, has received a letter clearing them for participation from their surgeon or treating physician. (3) Has had no seizures in the last year.

Licensed health care provider's signature		Printed Name	
Date		Phone Number	
Address		City/State/Zip	