

Old Dominion University Recreational Sports Department  
Outdoor Adventure Program (OAP)

**PARTICIPATION AND ASSUMPTION  
OF RISK CERTIFICATE**

(Please initial in each space)

I desire to participate in activities sponsored by the Old Dominion University Recreational Sports Department. \_\_\_ This participation is voluntary on my part. \_\_\_ I understand that participation in any type of recreational sports/outdoor adventure activity carries with it an inherent possibility of property loss, injury or death. This includes injury from contact with others and/or the playing environment, aggravation of pre-existing injuries and/or conditions, and effects of overexertion and heat injury. \_\_\_ I fully and freely assume all foreseeable risks of injury associated with the activities in which I have enrolled or will enroll for my voluntary participation in these activities. \_\_\_ I certify that I have had a physical examination within the last year and am physically fit to participate in the activities for which I have enrolled. \_\_\_ I also certify that I have a medical insurance policy currently in effect, and that I will keep a medical insurance policy current during any Outdoor Adventure Program related activity as a requirement for continued participation.

Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Please Print

I hereby certify that I have carefully read this form and fully understand its contents. If I did not fully understand the contents of this form, I have sought and obtained legal advice concerning its significance, and have gained an understanding of the meaning of the form before signing it. I also certify that I am over eighteen (18) years of age, and reaffirm all certifications made on this form.

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

UIN: \_\_\_\_\_ CONTACT NUMBER: \_\_\_\_\_

DATE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

MALE or FEMALE: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**I pledge to support the Honor System of Old Dominion University.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Outdoor Adventure Program (OAP) Assessment of Health Form

<i>To the best of your knowledge, have you had or currently have problems with any of the following?</i>			
Condition	Yes	No	If yes, please explain.
Allergies (seasonal, food, drugs, latex, bee stings, etc.)			
Asthma or Breathing problems			
Dental Problems			
Diabetes			
Epilepsy/Convulsions			
Head or Spinal Injury			
Heart Problems			
Hearing Problems			
Hospitalizations (when, why)			
Muscular Problems			
Surgery			
Vision Problems (do you wear glasses/contact lenses?)			
Are you currently pregnant?			
Other:			

Please list all prescription and over-the-counter medications you take regularly:

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Please list any other medical conditions you think we need to be aware of:

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Do you have any food considerations that we need to know about? (e.g. vegan, vegetarian?)

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Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Note: A new Health Form must be completed and signed each academic year.**