Medical Form

Please complete this form to the best of your ability, as it is in the best interest of yourself, your fellow trip members, and your guides that all of the information provided is accurate and complete. Completion of this form is mandatory for trip participation and must be returned to our office at least 30 days prior to departure. Your answers are for our records only and will be considered confidential.

Participant's
Name:_____Date:_____
Trip Name:_____Trip
Date:_____
Date of
Birth:_____Sex:_____Height:_____Weight:_____
In case of emergency
call:_____Phone:_____
Name of your
physician:_____Phone:_____
Medical Insurance
Provider:_____
Identification
Number:_____
Evaluate your health:
Fair_____Good_____Excellent_____
Evaluate your physical condition: Below average___Average____Above
average____Excellent_____
Evaluate your swimming ability:
Poor_____Fair_____Good_____Excellent_____
Date of your last tetanus
inoculation:_____
(**Note**: For all trips, it is **mandatory** that you have a tetanus shot within the last ten years.)
Has there been any change in your general health the past year? YES NO
If so, please
explain_____
Are you now under the care of a physician? YES NO
If so, what is the condition being treated?

_____
Have you had a serious illness, injury, or operation? YES NO
If so, what was the illness, injury, or operation and date?

_____
Have you been hospitalized or had a serious illness within the past five years? YES NO
If so, what was the nature of the illness and date?

_____
Do you wear contact lenses? YES NO
Any serious trouble associated with any previous dental treatment? YES NO
List any special dietary requirements or food
allergies:_____

Do you have or have you had any of the following diseases or problems:
Allergies YES NO If so, to what:?

_____

Arthritis YES NO
Asthma or hay fever? YES NO
Back problems YES NO
Cardiovascular disease: heart trouble, heart attack YES NO
Coronary insufficiency, stroke, coronary
occlusion,arteriosclerosis YES NO
Fainting spells or seizures YES NO
Hepatitis, jaundice or liver disease YES NO
High blood pressure YES NO
HIV YES NO
Hives or skin rash YES NO
Inflammatory rheumatism (painful swollen joints) YES NO
Kidney trouble YES NO
Knee problems YES NO
Low blood pressure YES NO
Tendonitis, Tenosinovitis, or Carpal-tunnel syndrome YES NO
If so, date and
details_____
Shoulder problems YES NO
Abnormal bleeding associated with
extraction, surgery or trauma YES NO
Anemia or other blood disorder YES NO
Women: Are you pregnant? YES NO
Are you taking any of the following?
(Please print the drug name.)
Antibiotics or sulfa drugs YES
NO_____
Anticoagulants (blood thinners) YES
NO_____
Antihistamines YES
NO_____
Anti-inflammatories YES
NO_____
Cortisone (steroids) YES
NO_____
Digitalis or drugs for heart condition YES NO

_____
Insulin YES NO
Nitroglycerin YES NO
Pain Killers YES NO

_____
Other YES NO

_____
Are you allergic or had a reaction to:
Anti-inflammatories YES NO
Aspirin YES NO
Barbiturates, sedatives, sleeping pills YES NO
Codeine or other narcotics YES NO
Iodine YES NO
Local anesthetics YES NO

Penicillin or other antibiotics YES NO
Sulfa drugs YES NO
Other YES NO
Do you have any disease, condition, or problem not listed above that you think we should know about? If so, please explain._____

_____

Note to participants traveling outside Canada and the U.S.: Please check with your local travel clinic for current inoculation requirements and other health recommendations for your destination.

I am medically, physically, and in all other respects, fit and fully able to participate in adventure travel and have no special medical requirements or conditions except as noted above. Should there be any change(s) related to my health or my ability to participate in the trip, I will notify the office and/or guide immediately.

Signature_____Date_____