



Medical Form

Please complete and return to our office as soon as possible as the following information is essential in informing our guides of any special precautions or needs that may be required. All medical forms will be kept in confidence.

Participants Name _____ **Date** _____

Trip name _____ **Trip date** _____

Date of birth _____ / _____ / _____ **Sex** _____ **Height** _____ **Weight** _____

In case of emergency call _____ **Phone (_____)** _____

Health: good/fair/poor **Physical conditioning:** good/fair/poor **Swimming:** good/fair/poor

Date of last tetanus inoculation(within the last ten years) _____

Any serious illness, injury, hospitalization in the last 5 years? Yes / No
If yes please explain _____

Any allergies ? _____ **Arthritis ?** _____ **Asthma ?** _____

Cardiovascular disease ? _____ **High blood pressure?** _____ **Low blood pressure?** _____

Abnormal bleeding ? _____ **Anemia ?** _____ **Diabetes?** _____

Are you currently taking any prescription drugs? Yes / No **If yes please print drug name and please bring an extra prescription of the drug in case of loss** _____

Are you allergic to any drugs? _____ **Women: are you pregnant? Yes / No**

Do you wear contact lenses ? Yes / No **Do you have dietary requirements ? Yes / No**

If yes please specify _____

Do you have any disease, condition, or disorder not listed that we should know about ? If so please explain: _____

The information provided is accurate and complete.

Signature of participant _____ **Date** _____