



MEDICAL HISTORY FORM

Please complete this form accurately and completely. Most medical problems do not preclude participation on our sea kayaking activities. However, environmental factors and remote destinations with no medical facilities or means of rapid evacuation may create a risk that is beyond our expectations. Our staff is well trained in wilderness first aid and carry a first aid kit, but most trips do not have an accompanying doctor.

The medical form will go with the activity leader Under Privacy provisions we have no intention or desire to record any of these details. They will only be used in an emergency to assist your care.

Please return the completed medical form promptly.

Sea Kayak Activity: Start Date NAME Can you swim? Yes / No Contact Number (in case your guide needs to contact you about this form) Left / Right Handed ? BIRTHDATE HEIGHT WEIGHT SPECIAL DIETARY REQUIREMENTS

IN CASE OF EMERGENCY PLEASE CONTACT

Name Relationship Address Home Phone Work Phone Doctors Name Doctors Phone

PLEASE LIST ALL INFORMATION REGARDING THE FOLLOWING

Physical condition Known Allergies (list) Do you suffer from Anaphylaxis (severe allergic reaction)? Do you have any physical limitations? Date of last TETANUS INNOCULATION OR BOOSTER (Must be current in the last 10 years) Medications? Yes / No If yes please provide details Have you been under a doctor's care in the last 12 months? Yes / No If yes please provide details Do you wear glasses or contact lenses?

ANY HISTORY OF THE FOLLOWING (if so please add details - over page if insufficient space)

1. Raised blood pressure? Yes / No 2. Heart or circulatory disease? Yes / No 3. Asthma? Yes / No If yes, how often are the attacks? 4. Epilepsy? Yes / No List medication if any and last attack. 5. Diabetes? Yes / No If on medication list type. 6. Pregnancy? (now) Yes / No If yes at which stage If pregnant have you been tested for gestational diabetes? 7. Ulcers? Yes / No 8. Digestive or bowel disorders? Yes / No 9. Joint injury? Yes / No Specify date and joint 10. Surgical operations? Yes / No If yes, specify 11. Mental/ Emotion instability Yes / No Any additional details

Signature of participant: Date: