

Health History / Personal Information



Name: _____ Date: _____

Course: _____ Course date(s): _____

We require full disclosure of your current health. The information you provide may assist people in the event of an accident. Before you fill this form out, please read it carefully; full and accurate completion of all sections is very important.

Gender: F or M Age: _____ Date of Birth: _____ Height: _____ Weight: _____
(to help us choose the best equipment for you)

Please list all information regarding the following:

Allergies: _____

Special food requirements: _____

Disabilities: _____

Blood type: _____

Heart conditions: _____

Past/current injuries or illnesses: _____

Current medications: _____

Phobias or fears: _____

Do you have asthma? _____

Can you swim? _____ Do you wear glasses / contact lenses? _____

Doctor's name: _____ Doctor's phone: _____

Doctor's address: _____ City: _____ State: _____ Zip: _____

Health insurance provider: _____ Policy / ID number: _____

Is there anything else that we should know that will help us keep you safe? _____

| | |
|--|-----------------------------------|
| In case of emergency, please contact: | |
| Name: _____ | Relationship to you: _____ |
| Home phone: _____ | Other phone (work or cell): _____ |

What are your goals and expectations for this course/trip? (please write on back of page if you need more space)

Thank you for completing this form!