Trip No: _____

PERSONAL INFORMATION

The logistics of wilderness and backcountry travel necessitate being a long way from hospitals, doctors, and pain-relieving medications. Because of the environmental and physical challenges that are inherent in wilderness travel, all trips are accompanied by a person trained in First Aid. Depending on the location, evacuation to a medical facility may be complicated, protracted, and expensive. In the event of illness or injury, and to provide appropriate emergency care, we need to be aware of any pre-existing medical or health conditions you may have that could be aggravated as a result of this experience. We respectfully urge you to be as thorough as possible in providing the information requested. Be sure to read both sides of this form. All information will remain confidential. We sincerely thank you for your cooperation.

CONTACT INFORMATION		
NAME:		
ADDRESS:		
CITY:	STATE:	ZIP:
PHONE:	FAX:	EMAIL ADDRESS:

IN CASE OF AN EMERGENCY		
NAME OF PERSON TO BE NOTIFIED IN CASE OF AN ILLNESS OR INJURY:		
RELATIONSHIP TO YOU:		
ADDRESS:		
CITY:	STATE:	ZIP:
PHONE:	FAX:	WORK PHONE:
YOUR PHYSICIAN'S NAME:		PHYSICIAN'S PHONE:
BIRTHDATE:	YOUR WEIGHT:	YOUR HEIGHT:

FOOD RESTRICTIONS

DO YOU HAVE ANY SPECIAL DIETARY RESTRICTIONS? IF SO, PLEASE CHECK ANY OF THE FOLLOWING:

❒ HYPOGLYCEMIC ❒ LOW-FAT ❒ DIABETIC ❒ NON-DAIRY
❒ VEGETARIAN ❒ VEGAN
❒ OTHER, PLEASE DESCRIBE:

MEDICAL INFORMATION
To help us understand and assess any medical problems that might arise during your trip, please comment on the following details of your recent medical history
ALLERGIES (FOODS, MEDICINES, INSECT STINGS, ETC.):
IF SEVERELY ALLERGIC, DO YOU CARRY AN ANA-KIT FOR EMERGENCY TREATMENT? ❒ YES ❒ NO
HAVE YOU BEEN HOSPITALIZED FOR SEVERE ILLNESS OR SURGICAL PROCEDURES DURING THE PAST TWO YEARS? IF SO, DESCRIBE AND PROVIDE APPROXIMATE DATE(S).
PLEASE INDICATE ANY POTENTIAL HEALTH PROBLEMS IDENTIFIED BY YOUR PHYSICIAN: ❒ DIABETES ❒ HEART ❒ RESPIRATORY ❒ EPILEPSY/SEIZURES ❒ OTHER, PLEASE DESCRIBE:
HAVE YOU HAD A TETANUS BOOSTER WITHIN THE PAST 7 YEARS? ❒ YES ❒ NO
DO YOU HAVE HIGH BLOOD PRESSURE? IF YES, PLEASE DESCRIBE.
DO YOU HAVE PALPITATIONS OF THE HEART, AN IRREGULAR HEARTBEAT, HEART MURMUR, OR POOR CIRCULATION? IF YES, PLEASE DESCRIBE.
ANY RECENT BROKEN BONES, SERIOUS SPRAINS, OR DISLOCATIONS? IF YES, PLEASE DESCRIBE.
PLEASE LIST YOUR PRESCRIPTIONS AND MEDICATIONS AND DESCRIBE THEIR PURPOSE. PLEASE INCLUDE DOSAGE INFORMATION IF POSSIBLE.
I hereby consent to any emergency care, hospital care, medical or surgical diagnosis and/or treatment to be rendered to me as found advisable for any injuries that may arise from my participation in a F/V Aimee O trip. I understand and agree that I am solely responsible for all applicable charges for such medical treatment, evacuation, and rescue. This medical information form is filled out completely and accurately, to the best of my knowledge. _____ _____ DATE PARTICIPANT SIGNATURE OR PARENT/GUARDIAN IF UNDER 18