# MEDICAL INFORMATION FORM

Name of Program/Trip: _____ Trip date: _____

Name _____ Date of Birth: ____/____/____
Address _____
City _____State _____ ZIP _____
Telephone (day) _____ (night) _____
Cell _____ email address: _____
The best way and time to reach you is _____

Height_____ Weight _____ Inseam _____ Shoe size _____
(This information is used to help us choose the appropriate kayak, wetsuit, and PFD)

Please list below any medications you are currently taking, the condition for which you take the medication, and the dosage amount:

| Medication | Medical Condition | Dosage |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Describe what physical activities you do:

Do you have, or have you had, any of the following conditions or symptoms:

| | | | |
|---|---|---|---|
| 1. | High blood pressure | ____ yes | ____ no |
| 2. | Heart disease | ____ yes | ____ no |
| 3. | Frequent shortness of breath | ____ yes | ____ no |
| 4. | Seizure disorder | ____ yes | ____ no |
| 5. | Asthma | ____ yes | ____ no |
| 6. | Diabetes | ____ yes | ____ no |
| 7. | Cancer | ____ yes | ____ no |
| 8. | Circulation Problems | ____ yes | ____ no |
| 9. | Headaches | ____ yes | ____ no |
| 10. | Intestinal problems | ____yes | ____ no |
| 11. | Hearing or visual impairment | ____ yes | ____ no |
| 12. | Motion sickness | ____ yes | ____ no |
| 13. | Broken bones | ____ yes | ____ no |
| 14. | Neck problem | ____ yes | ____ no |
| 15. | Back problem | ____ yes | ____ no |
| 16. | Arm or shoulder problem | ____ yes | ____ no |
| 17. | Knee, ankle or foot problem | ____ yes | ____ no |
| 18. | Leg problem | ____ yes | ____ no |

| | | | |
|---|---|---|---|
| 19. | Frequent fainting or dizziness | ____ yes | ____ no |
| 20. | Muscle cramps | ____yes | ____ no |
| 21. | Currently pregnant | ____ yes | ____ no |
| 22. | PMS or menstrual problems | ____ yes | ____ no |
| 23. | Allergies | ____ yes | ____ no |

**If you have answered 'yes' to any of the above items, please explain on back side and include the following:**

* What specific symptoms are occurring
* How often do symptoms/conditions occur
* How long symtom/conditions last
* How you care for symtom/condition
* Date of last occurence
• How symptom/condition restricts your activity in any way, including your ability to run, lift, climb, paddle, etc.

**Please list any dietary restrictions or food allergies we should know about? Are there foods you don't eat?** (If yes, please describe**)**

**Do you drink coffee?**

**Please describe typical meals you eat:**

Do you swim? ____ yes ____ no

EMERGENCY CONTACT INFO
**Person to contact in case of an emergency:** _____
**Phone number(s)** _____ **alt #** _____
**Relationship to you**_____

The information provided above is a complete and accurate statement of the physical and psychological factors, which may effect my participation in an H2Outfitters' program. I realize the failure to disclose such information could result in serious harm to myself and fellow customers and agree to indemnify and hold H2Outfitters harmless if all relevant information is not disclosed. I also agree to notify H2Outfitters should there be any change in my health status prior to the start date of the program. I also understand that H2Outfitters may request my physician's signature if there are any doubts as to my medical condition to participate in this program.

Date _____ Signature _____

Date _____ Signature of parent/guardian _____

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