CONFIRMATION PACKAGE
Medical Information Sheet
Please fill in all of the information below and **return this form to the office 1 month prior to your trip.**

Participant Information

Surname:
First Name:
Trip Name:
Healthcare #:
Birth Date:
Private Insurance #:
Insurance Expiry:
Addresses:

Telephone:

Physician Information

Name::
Telephone #:
Address:
Fax:

Medical History

- ❑ Ankle Injury
- ❑ Knee Injury
- ❑ Back Injury
- ❑ Joint Problems
- ❑ Seizures
- ❑ Stroke
- ❑ Epilepsy
- ❑ Asthma
- ❑ Respiratory Problems
- ❑ Ear Infections
- ❑ Diabetes
- ❑ ADD / ADHD
- ❑ Lactose Intolerance
- ❑ Severe Allergic Reactions
- ❑ Mental Illness
- ❑ Pregnant
- ❑ Menstrual Cramps
- ❑ Chicken Pox
- ❑ Measles
- ❑ Heart Problems
- ❑ High Blood Pressure
- ❑ Chest Pain
- ❑ Angina
- ❑ Other _____
- ❑ Other _____

If you have checked any of the above, please explain:

Immunizations

- ❑ Tetanus
- ❑ MMR
- ❑ DPT & Polio
- ❑ Meningitis
- ❑ Hepatitis
- ❑ Chicken Pox
- ❑ Other _____
- ❑ Other _____

Participant & Physician's Signature

_____ is in good health and there is no medical reason that will limit her/his ability to participate in all aspects of a wilderness canoe trip in a remote setting.

_____
Physician's Signature

_____
Parent/Guardian/Participant (if over 18 yrs)