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MEDICAL FORM - Day Programs

The information that you provide on this form will be kept confidential.

It is vital in that it will enable guides / instructors to reduce the risk of injury or illness complications, as well as aiding in the preparation of contingency plans if an emergency does occur. Withholding information may compromise the care provided and may contribute to injury or illness complications.

It will not be used to deny access to the program.

Personal Information

Name _____
Address _____ City _____ Prov./State _____
Postal/Zip Code _____ Phone (H) _____ Birth date _____
Doctor _____ Phone _____
Care Card # _____

Emergency Contact

Name _____ Relationship _____
City _____ Prov./State _____ Phone (H) _____ (W) _____

Health Information

How often do you engage in regular physical activity? _____ times per week Type of activity? _____

Swimming Ability Poor Fair Good Excellent

Known Allergies (food, drugs, insects, etc) _____

Describe reaction _____

Chronic Disability or Illness: (ie high blood pressure, heart conditions, epilepsy, diabetes, asthma, hayfever, emphysema; susceptibility to seasickness, colds, headaches, earaches, nosebleeds, fainting)

Are you on any medications? (prescription or nonprescription) _____

History of joint injury (tendinitis, bursitis, sprain, dislocation or other): _____

Do you feel that you have any psychological limitations (ie fear of water, fear of heights etc)?

Insurance

Please be sure that your insurance covers expenses caused by accidents in remote locations. Any costs arising from an unscheduled evacuation will be the responsibility of the participants.

Declaration

The above medical form is complete and accurate. I have read and understood all the above information.

Signature

Date

Parent/Guardian Signature (if participant under 18 yrs.)

Date