Adventure High Inc.

C0NFIDENTIAL MEDICAL HISTORY

PART 1

Tour/Program Dates _____ Date _____

Name _____ Birthdate ___/___/____ Age _____ Male/Female
Street _____ City _____
Province/State _____ Postal Code/Zip _____
Home Phone (___)_____ Business Phone (____)_____
Cell Phone (___)_____ Email _____

Height _____ Weight_____
Size EX-S S M L EX-L (for equipment selection)

Family Physician _____ Phone (___)_____

Street _____ City _____
Province/State _____ Postal Code/Zip _____
Cell Phone (___)_____ Business Phone (____)_____
Email _____

Emergency Contact _____ Relationship _____
Street _____ City _____
Province/State _____ Postal Code/Zip _____
Home Phone (___)_____ Business Phone (____)_____
Cell Phone (___)_____ Email _____

Is the applicant coved by a medical plan? Yes/No
By which province/state? _____ Policy Number _____
Does the applicant have other insurance coverage? _____
Name of insurance company _____
Policy Number _____
Street _____ City _____
Province/State _____ Postal Code/Zip _____
Business Phone (____)_____
Email _____

EACH PARTICIPANT IS RESPONSIBLE FOR ANY MEDICAL EXPENSES AND SHOULD BE COVERED BY THEIR OWN SICKNESS, ACCIDENT AND EVACUATION INSURANCE.
IN THE EVENT OF AN EVACUATION, COST MUST BE BORNE BY THOSE PARTICIPANTS. Please initial _____

PART 2

Give a brief statement of your general health_____

_____

	Check One	Comments
Do you have any present medical problem?	Yes___No___	
Are you currently taking medication?	Yes___No___	
Do you have any chronic disability or illness	Yes___No___	
Do you suffer from any heart condition	Yes___No___	
Do you suffer from headaches, dizziness, fainting	Yes___No___	
Do you have a current tetanus immunization (Must be within last ten years)	Yes___No___	
Are you allergic to any of the following (list severity of reaction)		
medications	Yes___No___	
food	Yes___No___	
insect bites	Yes___No___	
other	Yes___No___	
Do you suffer from motion sickness?	Yes___No___	
Do you have asthma?	Yes___No___	
Do you require a special diet?	Yes___No___	
Do you experience any form of seizures?	Yes___No___	
Do you have problems with your neck, back arms, ankle or knees that limit your activities?	Yes___No___	
Do you have diabetes?	Yes___No___	
Does your health prevent you from participating in any physical activities?	Yes___No___	

PARENTS MEDICAL CONSENT

This form is correct to my knowledge and the applicant described has permission to engage in Adventure High Inc. activities as noted. In the event that I cannot be reached in an emergency I hereby give Adventure High Inc. permission to use their best judgment in obtaining the best service for the above applicant. I also hereby give permission to the physician in attendance to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for the above applicant. We understand that any cost will be our responsibility.

Signature

Applicant's _____ Date _____

Parent or Guardian _____ Date _____

(if applicant is under legal age)