

Medical Information for Overnight Trips Only

Please list any current health conditions (If None, please state "NONE"):

Please explain any significant injuries, including treatment (If None, please state "NONE"):

Are there any fears, special needs, or recent events in the participant's life that may impact his/her experience or behavior during outdoor activities? If so, please explain in detail. (If None, please state "NONE"):

Do you feel that any aspect of the participant's mental or physical health may endanger him/herself, the guides, or other members of the group? Are there any activities that may physically or mentally cause too much exertion or anxiety on the participant? If so, please explain in detail. (If None, please state "NONE"):

Are there certain situations, conditions, allergies, foods allergies, or medications that may trigger a negative reaction in the participant? (If None, please state "NONE"):

Does the participant have a history of any of the following medical conditions?

- | | |
|--|---|
| <input type="checkbox"/> fainting | <input type="checkbox"/> headaches |
| <input type="checkbox"/> seizures | <input type="checkbox"/> stomach aches |
| <input type="checkbox"/> panic/anxiety attacks | <input type="checkbox"/> asthma or other breathing problems |
| <input type="checkbox"/> Other _____ | |

Current Height: _____ Weight: _____ Date of last physical exam: ___/___/_____
Doctor's Name: _____ Phone Number: ___-___-_____

Please list any medications that the camper will take, and any possible side effects that may occur.

Please list the date and reason for any hospitalizations and surgeries.

Does the participant suffer from any form of sleeping disorder (including insomnia or bed wetting)?

Yes No

If so, please explain and give usual precautions/ treatment:

I certify that the above information is true and accurate according to the best of my knowledge.

Participants' Name (Parent/Guardian if under 18): _____

Signature: _____ Date: ___/___/_____