

TRIP PARTICIPATION / MEDICAL FORM

Trip guests have the responsibility to select a trip appropriate to their abilities and health. If you have any medical problems which may impede your participation in this trip, please consult your physician.

Trip Departure Date _____

PLEASE PRINT LEGIBLY

LEGAL FIRST NAME	LAST NAME	ZIP CODE	BIRTHDATE	AGE	WEIGHT

NOTE: if your chest measurements exceed 52", please contact our office for additional information

Address _____ **E-Mail** _____

City _____ **State** _____ **Zip** _____

Phone (H) _____ **(C)** _____ **(W)** _____

MEDICAL

RELEVANT PRE-EXISTING CONDITION(S) _____

MEDS TAKEN FOR ABOVE CONDITION(S) _____

PHYSICAL LIMITATIONS _____

INSECT/MEDICAL ALLERGIES _____

Has your doctor advised against your taking or participating in any aspect of this trip? _____ **No** _____ **Yes**

OR I choose NOT to share any medical information _____ **Date** _____

Signature

DIETARY

FOOD ALLERGIES / OTHER _____