

**WELLS GRAY CHALETS AND WILDERNESS ADVENTURES
MEDICAL FORM**

The information contained in this form is confidential and will only be shared with the trip leader and medical personnel in the case of an emergency. No person shall be denied access to any trip based on the following information.

PARTICIPANTS NAME _____

BIRTHDATE (DMY) _____ WHICH TRIP ARE YOU JOINING? _____

DOCTORS NAME _____ PHONE _____

1) Do you have any ALLERGIES such as:

INSECT BITES DRUGS ASTHMA HAYFEVER

OTHER _____

2) Are you taking any PRESCRIPTION or NON PRESCRIPTION DRUGS? Y_____ N_____

 If yes, give details _____

3) Have you been under a DOCTOR'S CARE in the past year? Y_____ N_____

 If yes , give details _____

4) Have you had any MAJOR ILLNESSES, INJURIES, OR OPERATIONS?

Y_____ N_____ please specify _____

5) Do you suffer from any CHRONIC CONDITIONS such as :

() Diabetes () Epilepsy () Heart condition () Arthritis
() Headaches () Fainting () Bronchitis () Sleep Walking
() Other; please specify _____

6) When was your last tetanus inoculation or booster? YEAR _____

7) Please describe any food allergies or dietary restrictions _____

IN CASE OF AN EMERGENCY CONTACT:

NAME _____ RELATIONSHIP _____
ADDRESS _____ TELEPHONE _____

ALTERNATE NAME: _____ RELATIONSHIP _____
ADDRESS _____ TELEPHONE _____

All of the above information is accurate of today's date. If there are any changes between now and the trip, I agree to contact Wells Gray Chalets and Wilderness Adventures with the updated information.

PARTICIPANT'S SIGNATURE _____ DATE _____
If participant is under 19 years old.

PARENT / GUARDIAN'S SIGNATURE _____ DATE _____