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 ______________________________
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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 SIGNITURE ______________________________ DATE_________________
If participant is under 19 years old.

PARENT / GUARDIAN'S SIGNITURE___________________________ DATE _________________