ADVENTURE DISCOVERY TOURS, INC

RETURN THIS FORM TO _____BY: _____

Group Name: _____
Trip Dates: _____

Participant: _____
Address: _____ Zip: _____
Phone: (H): (_____)_____ (W): (_____)_____
(C): (_____)_____ (C): (_____)_____
Email: _____

In case of emergency notify/Relation: _____
Phone: (H): (_____)_____ (W): (_____)_____
Address: _____
Physician Name: _____
Phone: (_____)_____

HEALTH HISTORY

The following confidential information is vital and allows us to assess your individual needs

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Do you have any of the following conditions?	**YES**	**NO**
History of heat related illness:	( )	( )
Muscle or joint problems:	( )	( )
Back problems:	( )	( )
Cardiovascular problems:	( )	( )
Kidney problems:	( )	( )
Asthma (or other respiratory problems):	( )	( ) Inhaler dependant? _____
Diabetes:	( )	( ) Type? _____
Do you smoke:	( )	( )
Allergic reaction to bee stings/ant bites (circle)*:	( )	( ) (describe reaction below)
Allergic reaction to foods*: Reacts to: _____	( )	( ) (describe reaction below)
Other allergies*: Reacts to: _____	( )	( ) (describe reaction below)

_____
_____
_____

***Due to the remote wilderness setting of this trip, if you have a history of pronounced, progressive, or severe allergic reactions (especially those that compromise breathing)—you are required to provide and carry (2) Epi-pen kits and a supply of oral antihistamine tables.**

Allergic reaction to Penicillin:	( )	( )
Allergic reaction to Sulfa drugs:	( )	( )
Any medical condition that might be worsened due to conditions on the trip:	( )	( ) (Please describe in detail)

_____
_____
_____

(OVER)

Please describe any medical condition you currently have:

_____
_____
_____
_____
_____

List any medication you are currently taking and the condition it is treating:

_____
_____
_____
_____
_____

Please describe any dietary restrictions (including allergies). If vegetarian, please specify type of protein you eat: _____

_____
_____
_____

Can you swim?: _____

I attest to the fact that the above medical disclosure and personal history are truthful and complete.

SIGNATURE*: _____ DATE: _____
***If participant is under 18, parent/guardian signature required**

MEDICAL RELEASE STATEMENT:
In case of emergency, I understand that every effort will be made to contact immediate family or my physician. In the event that family/physician cannot be reached, I hereby give permission to the physician selected by the Adventure Discovery Tours, Inc. staff to hospitalize, secure proper treatment, order injections, anesthesia, and/or surgery for and make other decisions regarding my medical care and treatment.

SIGNATURE*: _____ DATE: _____
***If participant is under 18, parent/guardian signature required**