



MEDICAL & EMERGENCY FORM

PLEASE FILL IN ONE FORM PER PERSON, EVEN IF A COUPLE OR IN SAME FAMILY

NAME OF PARTICIPANT: _____

HEIGHT: _____ WEIGHT: _____ SWIMMING ABILITY: YES ___ NO ___

PREGNANT: YES ___ NO ___ IF YES, EXPECTED DUE DATE _____

MEDICAL CONDITIONS WE SHOULD BE AWARE OF (PAST AND PRESENT): YES ___ NO ___

IF YES, PLEASE SPECIFY: DIABETES / HEART DISEASE / EPILEPSY / ASTHMA / HIGH BLOOD PRESSURE / BACK PROBLEMS / DISLOCATIONS / OTHER, PLEASE DESCRIBE:

ARE THERE LIMITATIONS ON ANY OF THE ACTIVITIES INCLUDED IN OUR TOURS? YES ___ NO ___

IF YES, PLEASE SPECIFY: _____

MEDICATIONS YOU ARE TAKING WITH DOSAGE:

ALLERGIES / DIETARY RESTRICTIONS (PLEASE DESCRIBE IN DETAIL. FOR INSTANCE, IF YOU ARE VEGETARIAN, VEGAN, LACTOSE INTOLERANT, ALLERGIC TO FISH, NUTS, ETC.):

MEDICAL INSURANCE COVERAGE:

COMPANY _____

POLICY NUMBER _____

CONTACT PERSON IN CASE OF EMERGENCY: _____

RELATIONSHIP _____

ADDRESS _____

PHONE NUMBERS Home _____ Work _____