

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_

In Case of an emergency, please contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**PAST HISTORY:**

Do you have any of the following? (please Circle one) If yes, please describe?

Allergies	Yes	No	_____
Food Allergies	Yes	No	_____
Medication Allergies	Yes	No	_____
Asthma or other Respiratory Problems	Yes	No	_____
Back trouble	Yes	No	_____
Diabetes	Yes	No	_____
Learning Disability (Optional)	Yes	No	_____
Heart Condition	Yes	No	_____
Heat exhaustion	Yes	No	_____
High Blood Pressure	Yes	No	_____
Nose Bleeds	Yes	No	_____
Physical Handicap	Yes	No	_____
Sinus Problems	Yes	No	_____
Other (please explain):			

Do you need a special diet? If so, please describe.

\_\_\_\_\_

 Do you take any medications regularly? \_\_\_\_\_  
 (Please bring a complete supply of your prescription for the entirety of the trip. Also, have a copy of your prescription with you.)