LASTING ADVENTURES, INC.
"Creating Yosemite Memories that Last a Lifetime"
P.O. Box 1078 · Groveland, CA. 95321 · 1-800-513-8651
www.LastingAdventures.com

Participant Medical Form

Confidential information used for medical purposes only.

Participant's Name: _____ Date of Birth: ___/___/___ Sex: ___ Age: ____

Street Address: _____ Height: _____ Weight: _____

City / State / Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Emergency Contact (1): _____

Street Address: _____

City / State / Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

If not available in an emergency, notify:

Name / Relationship: _____ Phone: _____

Additional Phone Numbers: _____

Name of physician: _____ **Phone:** _____

Name of dentist/orthodontist: _____ **Phone:** _____

Insurance: Each participant is responsible for medical expenses.

Insurance Company: _____

Policy Number: _____ Group Number: _____

IMPORTANT – This box must be completed for Participation

This health history is correct to the best of my knowledge. As far as I am aware, I am physically and emotionally capable of participating in all activities, unless noted otherwise herein. If I have any questions or doubts regarding my capability to participate, I understand that it is my responsibility to consult with the appropriate medical provider(s) to so confirm, prior to my participation.

I hereby give my permission to Lasting Adventures and its representatives and affiliates (including field staff and outfitters):

1. To access and review my medical information included on this form.
2. To make all medical information available to medical personnel as requested.
3. To provide medications or medical care to me if needed.

Emergency Authorization: In the event of a medical emergency, I authorize Lasting Adventures to provide emergency first aid treatment to me and/or refer treatment to other medical practitioners. This care may be given under whatever conditions are necessary to preserve my life, limb or well-being. I agree to pay all costs associated with any medical care and related transportation and to indemnify and hold Lasting Adventures harmless for any costs incurred.

This form may be photocopied for use in the field.

Signature of participant: _____ **Date:** _____

I also understand and agree to abide by the restrictions placed on my camp activities.

GEAR REQUEST

____ Backpack ____ Sleeping Bag ____ Sleeping Pad ____ Eating Gear (bowl, cup, spork) ____ Trekking Poles

____ Tent (Indicate 1,2, or 3 person). Sharing with: _____

Participant Name: **Adventure Dates:**

Health History:
Please list any and all conditions that may impact your participation, including but not limited to: heart conditions, asthma, diabetes, epilepsy or other seizure disorders, and psychiatric conditions. For each condition listed, give approximate dates and explain in the space below as needed.

Are you currently under the care of a physician, mental health provider, or other medical provider for the conditions listed?

Are there any specific activities to be discouraged or limited by physician advice?

Please describe your personal conditioning program to prepare for this trip:

MEALS: If meals are provided on your trip, do you have any **Dietary Restrictions**?

Circle all that apply: Coffee? Yes / No Tea? Yes / No Cream? Yes / No Sugar? Yes / No

ALLERGIES: Please list any allergies including medicines, foods, plants, bites, stings, etc.

Allergy	Reactions	Medication Required

MEDICATION: Please list any prescribed medication that is currently taken. Please indicate what will be brought on the Adventure.

Medication	Condition	Dosage (amount/frequency)	Side Effects

Please include any additional conditions or concerns we should know about: