

Nomadic Routes Inc.

GUEST HEALTH INFORMATION

All information is kept confidential and is not used to deny access to the activity.

Name _____ Date of Birth (dd/mm/yy) _____

Address _____ Postal Code _____ Country _____

Phone (H) _____ (W) _____ (F) _____ Email _____

Health Care Provider _____ Policy Number _____

Additional Policies _____ Policy Number _____

Name of Physician _____ Phone _____

Date of last Tetanus Shot (dd/mm/yy) _____ must be within the last ten years.

Do you wear a medic alert? Yes No

Do you wear contact lenses? (Circle) Yes No If yes, please bring a spare pair of glasses.

List regular exercise, training program and related outdoor experiences -Type, times per week, intensity, location

Do you have a history of any of the following? (Circle all that apply)

Bronchitis	Heart disease	Pleurisy	Dislocations
Asthma	Epilepsy	Diabetes	Joint problems
Pneumonia	High blood pressure	Hypoglycemia	Other

Explanation/Details _____

Have you had any recent operations, illness, or injuries? (Circle) Yes No

If yes, when _____ Explanation of treatment _____

With the known activities of this trip, do you know of any physical limitations or medical disorders that may affect your performance in this outing? (Circle) Yes No If yes, please explain

Allergies

Do you have allergies? Yes No Please list (include food allergies) _____

Explanation of severity, previous and recent reactions _____

Medications

List any current medications you are taking _____

Times taken _____ Where will you carry it _____

Please provide information about the medication (reason for taking, administering, side effects)

In Case of Emergency, Contact:

Name _____ Relationship _____

Address _____ Phone _____

Name _____ Relationship _____

Address _____ Phone _____

This information is **true** to my knowledge. I have **not withheld** information, which may affect medical treatment.

Signature _____ Date _____

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