

Adventures Without Borders - Medical Profile/Confidential

Personal Data

Name: _____ Sex: M ___ F ___

Address: _____

_____ Phone: _____

Birthdate: _____ Height: _____ Weight: _____

Medical History

Physician: _____

Address: _____

_____ Phone: _____

Date of last physical: _____

Has your physician, at any time restricted you from physical activity? ___ No ___ Yes

If yes, specify: _____

Do you smoke: ___ No ___ Yes If yes, how much? _____

Are you on any form of medication (prescription or non-prescription)? ___ No ___ Yes

If yes, list the type and the dosage _____

Have you had any injuries or surgeries?

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Additional Information: _____

Do you have any of the following:

Heart Condition ___yes ___no If yes, specify: _____

Neurological Condition ___yes ___no If yes, specify: _____

Respiratory ___yes ___no If yes, specify: _____

Asthma ___yes ___no

High Blood Pressure ___yes ___no If yes, are you taking medication? _____

Gastro-intestinal ___yes ___no If yes, specify: _____

Hernia ___yes ___no

Epilepsy ___yes ___no

Diabetes ___yes ___no

Hypoglycemia ___yes ___no

Allergies ___yes ___no If yes, specify: _____

Dizziness ___yes ___no If yes, specify: _____

Health problems not listed above: _____

Additional information: _____

I (Print Your Name) _____

Certify the information on this form to be true. I take full responsibility for my health and level of fitness for the adventure program that I am undertaking. If required, I will obtain medical clearance from my physician before taking part in this program - specify your program including start and finish dates: _____

Signature: _____ Date: _____

Please print this medical profile form, fill it out and fax or mail it back to us. We believe that confidential information such as your medical profile should be best sent via fax or regular mail.

Fax Number: 1 (604) 925-9587

Adventures Without Borders

4910 Keith Rd.

West Vancouver, B.C.

V7W 2N1 Canada