

**WELLS GRAY CHALETS AND WILDERNESS ADVENTURES  
MEDICAL FORM**

The information contained in this form is confidential and will only be shared with the trip leader and medical personnel in the case of an emergency. No person shall be denied access to any trip based on the following information.

PARTICIPANTS NAME \_\_\_\_\_

BIRTHDATE (DMY) \_\_\_\_\_ WHICH TRIP ARE YOU JOINING? \_\_\_\_\_

DOCTORS NAME \_\_\_\_\_ PHONE \_\_\_\_\_

1) Do you have any ALLERGIES such as:

INSECT BITES                  DRUGS                  ASTHMA                  HAYFEVER

OTHER \_\_\_\_\_

2) Are you taking any PRESCRIPTION or NON PRESCRIPTION DRUGS?    Y\_\_\_\_\_    N\_\_\_\_\_

    If yes, give details \_\_\_\_\_

3) Have you been under a DOCTOR'S CARE in the past year?    Y\_\_\_\_\_    N\_\_\_\_\_

    If yes , give details \_\_\_\_\_

4) Have you had any MAJOR ILLNESSES, INJURIES, OR OPERATIONS?

Y\_\_\_\_\_ N\_\_\_\_\_    please specify \_\_\_\_\_

5) Do you suffer from any CHRONIC CONDITIONS such as :

( ) Diabetes                  ( ) Epilepsy                  ( ) Heart condition                  ( ) Arthritis  
( ) Headaches                  ( ) Fainting                  ( ) Bronchitis                  ( ) Sleep Walking  
( ) Other; please specify \_\_\_\_\_

6) When was your last tetanus inoculation or booster?    YEAR \_\_\_\_\_

7) Please describe any food allergies or dietary restrictions \_\_\_\_\_  
\_\_\_\_\_

**IN CASE OF AN EMERGENCY CONTACT:**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_ TELEPHONE \_\_\_\_\_

ALTERNATE NAME: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_ TELEPHONE \_\_\_\_\_

All of the above information is accurate of today's date. If there are any changes between now and the trip, I agree to contact Wells Gray Chalets and Wilderness Adventures with the updated information.

PARTICIPANT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
If participant is under 19 years old.

PARENT / GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_