SKYLINE ADVENTURE SCHOOL

Quality Guided Trips & Professional Outdoor Instruction

P.O. Box 8321, Missoula MT 59807
PHONE: (1)406-322-3065 (USA) / (51)43-427097 (PERU)
Email: info@skyline-adventures.com
Fax: (51)43-42-70-97 (Peru)
www.Skyline-Adventures.com

PARTICIPANT MEDICAL FORM

Please carefully read and complete the following form. All information will be held confidential and is in the interest of safety during your course or trip. Answering "yes" to any question does not automatically disqualify anyone from a trip, it only helps the guides to be prepared!

Name: ____

If you circle "YES" on any of the following questions, please explain on the space provided below.
Do you currently have or do you have a history of:

#	Condition		
1.	Bleeding or blood disorders	YES	NO
2.	Eating disorders	YES	NO
3.	Hepatitis or other liver disease	YES	NO
4.	Neurological problems – Epilepsy, Seizures	YES	NO
5.	Dizziness or fainting episodes	YES	NO
6.	Treatment or medication for menstrual cramps	YES	NO
7.	Disorders of the urinary or reproductive tract	YES	NO
8.	Current or prior cardiovascular disease or other cardiac problems	YES	NO
9.	A family history of cardiac disease	YES	NO
10.	Gastrointestinal disturbances	YES	NO
11.	Diabetes	YES	NO
12.	Hypertension	YES	NO
13.	Frostbite or frostnip	YES	NO
14.	Acute Mountain Sickness or history of problems at altitude	YES	NO
15.	Heat stroke or other heat related illness	YES	NO
16.	High blood pressure	YES	NO
17.	Obesity	YES	NO
18.	Are you a smoker?	YES	NO
19.	Respiratory problems – Asthma	YES	NO
20.	Unexplained chest pain, shortness of breath or palpitations	YES	NO
21.	High blood cholesterol	YES	NO
22.	Knee, hip, ankle, shoulder, arm or back injuries	YES	NO
23.	Dietary preferences i.e. Vegetarian, Vegan	YES	NO

If you answered "yes" to any of the above, please explain below – include dates of last occurrence.

#	EXPLANATION:

Are you currently taking any medications? YES NO

Medication	Dosage	Frequency	Side effects or restrictions

Allergies to Food, Insects, Medication, and other:

Allergies to:	Reaction	Treatment	Date of last episode

Briefly describe any pertinent previous experience at altitude AND your current level of acclimatization (to the best of your understanding)

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____

Have you been hospitalized in the last 5 years? If so, explain: YES NO

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Have you received treatment or counseling from a mental health professional in the last two years? YES NO Please explain:

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____

Dates of treatment: From ___/___/___ To ___/___/___

Date of your last tetanus shot ___/____/____

All of the above information is true and accurate. I understand that failure to disclose facts pertaining to the safety of the trip could result in my expulsion from the program. I agree to inform SAS if any of the above conditions should change prior to the trip start. I give permission for a physician to administer medical care or treatment, at my expense, in the event that I should become injured or ill while involved in any program with Skyline Adventure School.

Client Signature ____ Date ___/____/____

PHYSICIAN'S EXAMINATION:

The Skyline Adventure School operates trips and courses in the Andes Mountains of Peru. Participants spend extended amounts of time in wilderness settings, (8 hours or more away from medical facilities) mountaineering, rock climbing and back packing. Participants will be required to carry backpacks that weigh up to 15 kilos and will be physically exerting themselves in a cold, high altitude environment.

Being in sound health is imperative to the safety and success of the course.

Blood Pressure ________/________

Height _____________

Weight _____________

Foot Size _____________ (for fitting plastic boots)

Upon examination, this applicant is fit and able to participate in an outdoor course involving continual physical activity, carrying a heavy backpack, cold weather, and high altitude (above 5000m) in a remote wilderness setting.

Physicians Recommendations:

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Name of Physician ___________________________________

Phone # (___)________________________

Date of examination ___/___/____

Physician's Signature ______________________________________