SKYLINE ADVENTURE SCHOOL
QUALITY GUIDED TRIPS & PROFESSIONAL OUTDOOR INSTRUCTION

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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:

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)

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

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 Skyline Adventure School 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 may be required to carry backpacks that weigh up to 20 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 trip.

Blood Pressure _____/_____

Height _____

Weight _____

Foot Size _____ (for fitting plastic boots)

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

Physicians Recommendations:

Name of Physician _____

Phone # (___)_____

Date of examination ___/___/____

Physician's Signature _____

◯ By checking here you indicate that you are voluntarily opting out of a physician's exam and assume full responsibility for disclosing any medical information which could affect your health or performance while on your trip with Skyline Adventures and for any consequences which may occur as a result. Please sign above.