Health Form

The following information is optional

Last Name: _____ First Name: _____

Please indicate below if you have one or more of the following conditions:

High Blood Pressure	Yes	No	Allergies	Yes	No
High Cholesterol Level	Yes	No	Arthritis	Yes	No
Diabetes	Yes	No	Heart Murmurs	Yes	No
Epilepsy/Seizures	Yes	No	Lung Disease	Yes	No
Pregnant	Yes	No	Shortness of Breath	Yes	No
Smoke Tobacco	Yes	No	Hernia	Yes	No
Asthma	Yes	No	Back Problems	Yes	No
Recent Surgery	Yes	No	Joint Pains	Yes	No

If you answered yes to any of the above conditions please explain:

Please list any other health-related conditions that may affect your kayaking abilities:

List all prescriptions and/or over the counter drugs you are presently taking:

Please list any medications and/or food you are allergic to:

Are you returning to exercise after an extended period of time?

List any food preferences or diets below:

Medical Insurance Information (primary coverage)

Insurance Company Name: _____
Policy Number: _____
Are you going to have trip insurance coverage while you are here? Yes No
If yes:
Insurance Company Name: _____
Policy Number: _____