SILA SOJOURNS

MEDICAL AND PERSONAL FORM

Please complete this form to the best of your ability as it is in the interest of yourself, your fellow trip members, and your guides that all of the information provided is accurate and complete. Completion of this form is mandatory for trip participation and must be returned to our office at least 30 days prior to departure. Your answers are for our records only and will be considered confidential.

Participants Name_____ Date_____

Date of Birth:_____ Sex_____ Height_____ Weight_____

In case of emergency call: _____Phone: (h)_____(w)_____

Evaluate your health: Fair_____ Good_____ Excellent_____

Evaluate your physical condition:
Below average____ Average_____ Above average____ Excellent_____

Evaluate your swimming ability:
Non-swimmer_____ Poor_____ Fair____ Good____ Excellent_____

Name & phone number of your physician_____

Date of your last tetanus innoculation
Note: It is recommended that you have had a tetanus shot within the last 5 years

Has there been any change in your general health the past year? Yes No
If so, please explain:_____
Are you now under the care of a physician?____ If so, what is the condition being treated?_____

Have you had any serious illness, injury, or operations? Yes No
If so, what was it?_____

Have you been hospitalized or had a serious illness within the last five years?
If so, what was the problem? _____

Do you have, or have you had, any of the following diseases or problems:

Allergies	Yes	No
(If so, to what?_____)		
Arthritis Asthma or hay fever?	Yes	No
Cardivascular disease: heart trouble, heart attack	Yes	No
Coronary insufficiency or occlusion, arteriosclerosis, stroke	Yes	No
Fainting spells or seisures	Yes	No
Hepatitis, jaundice or liver disease	Yes	No
High blood pressure	Yes	No

Hives or skin rash	Yes	No
Inflammatory rheumatism (painful swollen joints)	Yes	No
Kidney trouble	Yes	No
Low blood pressure	Yes	No
Tendonitis, Tenosinovitis or Carpal-Tunnel syndrome	Yes	No
Have you has abnormal bleeding associated with previous extraction, surgery or trauma?	Yes	No
Do you have any blood disorder such as anemia?	Yes	No
Women: Are you pregnant?	Yes	No

Are you taking any of the following (please print the drug name):

Anticoagulants (blood thinners)	Yes	No
Antihistamines	Yes	No
Anti-inflammatories	Yes	No
Cortisone (steroids)	Yes	No
Digitalis or other drugs for heart conditions	Yes	No
Insulin	Yes	No
Nitroglycerin	Yes	No
Pain Killers	Yes	No
Other	Yes	No

Are you allergic, or have you reacted adversely to:

Anti-inflammatories	Yes	No
Aspirin	Yes	No
Barbituates, sedatives or sleeping pills	Yes	No
Codeine or other narcotics	Yes	No
Iodine	Yes	No
Local anesthetics	Yes	No
Penicillin or other antibiotics	Yes	No
Sulfa drugs	Yes	No
Other _____	Yes	No
Do you have any food allergies	Yes	No

To what foods & what is the reaction?_____
_____

Do you wear contact lenses?

Have you had any serious trouble associated with previous **dental treatment**?

List any special dietary requirements:_____
(Note: Please let us know now; it is too late once you arrive)

Do you have any disease, condition, or problem not listed above that you think we should know about? If so, please explain:
_____

PLEASE MAIL FORM to SILA SOJOURNS at **9 Kokanee Place, Whitehorse YT Y1A5Y2 Canada**