TO: College of the Rockies, Fernie Campus, Box 1770, Fernie, BC, VOB 1MO
Phone: 250-423-4691 Fax: 250-423-3932

MOUNTAIN ADVENTURE SKILLS TRAINING PROGRAM
MEDICAL HISTORY

Name: ____ Birthdate: _________________________
Address: ____
Phone: _______________________

IN CASE OF EMERGENCY CONTACT

Name: ___________________________ Phone: _________________ Relation: _______________
Address: ____
Doctor: ______________________________ Phone: ________________________________
Medical Insurance Plan: ______________________________
Personal Health #: _______________________ ID. & DEP#: ___________________________

Allergies: ____
Date of last tetanus inoculation or booster ________________________ [for multi-day trips, current (within last 10 years) tetanus boosters are mandatory]
Are you on any medications (prescription or non-prescription): YES __________ NO __________
If yes, please specify ____
Have you been under a doctors care in the last 12 months? _________ If yes, give details
____
____
Chronic Disability or illness (ie. heart condition, diabetes, etc.)
____
History of Joint Injury (please describe and specify ______________________________________
____

Eyesight: Ex. _____ Fair _____ Poor _____ Glasses ______ Contact Lenses ______
(It is recommended that if you are dependent upon glasses or contacts for adequate vision bring a spare set of glasses with you)
Do you have any physical limitations: ____
____
Do you have any psychological limitations (ie. fear of water) ______________________________
____

If any of the above information changes during the program. I will inform the coordinator of the program.

Signature: ________________________________ Date: ____________________________
(parent/guardian if under 19 years of age)

***Please note: failure to disclose any medical conditions or problems may jeopardize the safety of the entire group.**