Mountain Skills Semester - Health Form

This form can be emailed to info@yamnuska.com, faxed to **1 403 678 4450** or mailed to **Yamnuska Mountain Adventures 200, 50 Lincoln Park, Canmore, Alberta, T1W 1N8, Canada**.

TO BE COMPLETED BY PARTICIPANT

Name:……..	Home Phone:……..
Address:……..	Cell Phone:……..
……..	Email: ……..

Health Insurance Card Number: ……....	Are you the applicant covered by a public/provincial medical plan?
Birthdate (day/month/year): …….....	Yes ☐ No ☐
Height: ……..…….....	
Weight: ……..…….....	By which province?
Gender: ☐Female ☐Male	

Family Physician:...……..……..	Do you the applicant have other private medical insurance coverage?
Phone:...……..…….....	Insurance Company: ……..……
Fax:…...……..…….....	Policy number: ……..…….....
Address: ……..…….....	Phone: ……..…….....
……..…….....	

EMERGENCY CONTACTS: (Person to be notified in case of emergency)

Name: ...…….....	Name: ...…….....
Home Phone: ...…….....	Home Phone: ...…….....
Work Phone: ...…….....	Work Phone: ...…….....
Cell Phone: ...…….....	Cell Phone: ...…….....
Relationship: ...…….....	Relationship: ...…….....

EACH PARTICIPANT IS RESPONSIBLE FOR ANY MEDICAL EXPENSES, INCLUDING MEDICAL EVACUATION AND SHOULD BE COVERED BY THEIR OWN SICKNESS AND ACCIDENT INSURANCE. For all travel insurance requirements we recommend the Simpson Group (please see our website for more details).

MEDICAL HISTORY:

1.	Give a brief statement of your general health:	
2.	Height:	Weight:
3.	Do you have any present medical problems?	□No □Yes – describe:
4.	Are you taking any medications?	□No □Yes – describe:
5.	List Medications including name, schedule with dosage amounts (in as much detail as possible please).	

Name of Medication/ What is it used for?	Schedule of Administration	Dosage Amounts

6.	Have you had a current tetanus immunization in the last 10 years?	□No □Yes
7.	Have you had any surgeries in the last 5 years?	□No □Yes – Give approx. dates/details:
8.	Are you allergic to any of the following? (Please list all allergies and describe nature and severity of reaction)	
	• Medications □No - □Yes – describe: • Foods □No - □Yes – describe: • Insect bites: □No - □Yes – describe: • Other □No - □Yes – describe:	
9.	Do you carry an Epi-pen?	□No □Yes – for which allergies?
10.	Do you smoke?	□No □Yes – describe:
11.	Have you had or do you have a substance abuse problem (alcohol, drugs, etc	□No □Yes – describe:
12.	Do you have problems with vision or hearing?	□No □Yes – describe:
13.	Do you have motion sickness?	□No □Yes – describe severity:

14.	Do you have a history of high blood pressure or hypertension?	□No □Yes – identify & describe:
15.	Do you have heart murmurs; episodes of irregular heart beat; shortness of breath of chest pain on exertion?	□No □Yes – identify & describe:
16.	Do you have asthma?	□No □Yes (if yes) • What triggers it? • Has it been stable for the past year? □No □Yes • Do you take medication for your asthma? □No □Yes ○ **Please list medications used in Section #5.**
17.	Have you had or do you have ulcers, heartburn, or other intestinal problems?	□No □Yes – (describe severity & diet requirement)
18.	Do you require a special diet? Please note we can accommodate many different kinds of dietary restrictions & allergies.	□No □Yes – describe:
19.	Do you have any eating disorders: anorexia, bulimia?	□No □Yes – identify & describe:
20.	Do you have seizures?	□No □Yes – describe severity and frequency **Please list medications and dosages in Section #5.**
21.	Do you suffer from sever headaches, dizziness or fainting?	□No □Yes – identify and describe:
22.	Have you ever had a brain injury requiring treatment? **Includes concussions.**	□No □Yes – give date and severity:
23.	Do you have claustrophobia, agoraphobia, acrophobia? (strong fear of confined places, open areas, heights)	□No □Yes – identify and describe:
24.	Do you have problems with your neck, back, arms, ankles or knees that limit your activities?	□No □Yes – identify and describe:
25.	Do you have diabetes, hypoglycaemia, thyroid trouble or other endocrine problems?	□No □Yes – identify and describe:
26.	Have you had frostbite or a reaction to cold temperatures?	□No □Yes – identify and describe:
27.	Have you suffered from muscle cramps, heat exhaustion or had other reactions to warm temperatures?	□No □Yes – identify and describe:
28.	Does your health prevent you from participating in any physical activities?	□No □Yes – describe:
29.	Have you ever seen a psychiatrist, psychologist or psychotherapist?	□No □Yes (if yes) • Are you currently under treatment? □No □Yes • Have you been under treatment within the last 2 years? □No □Yes
30.	Do you have a learning disability?	□No □Yes – **Please list medications used in Section #5.**

31.	Do you have trouble communicating in English?	□No □Yes
32.	For females only: Are you pregnant?	□No □Yes (if yes please give due date)
33.	If you are over 30 years of age and any of the following conditions apply to you, we **STRONGLY SUGGEST** that you discuss with your physician the advisability of talking a stress electrocardiogram. a. High blood pressure. b. Long-term sedentary lifestyle. c. Diabetes. d. Smoke one or more pack of cigarettes daily. e. Overweight or obesity. f. A family history of heart disease. g. Previous cardiovascular disease.	

I understand that the program involves physically and mentally strenuous activity in a remote wilderness area for removed from the facilities of civilization.

The information provided above is a complete and accurate statement of the physical and psychological factors which may affect my participation in the Yamnuska Mountain Skills Semester. I realize that failure to disclose such information could result in serious harm to myself and fellow participants and agree to indemnify and hold Yamnuska Mountain Adventures harmless if all relevant information is not disclosed.

_____

Applicant's Name (please print)

_____ _____

Date Applicant's Signature

Yamnuska Office Use Only

Received Date:

Call Student? □No □Yes Date:

Comments: