

Kayaking can be a strenuous activity. If you have any questions regarding your health and participation in kayaking, please discuss it with your physician. We ask you for the following information to be aware of any potential problems and to help you safely enjoy this sport. Please us additional paper if necessary. All information will be kept in strictest confidence. Thank you.

Please Print:

Name: _____

Address: _____

Telephone: _____

E-Mail: _____

Describe your swimming ability and/or comfort in a water environment:

Describe your kayaking experience:

How would you describe your general health?

Please check the Yes or No column if any of these conditions apply to you.

Yes	No	
<input type="radio"/>	<input type="radio"/>	Diabetes
<input type="radio"/>	<input type="radio"/>	Heart Disease
<input type="radio"/>	<input type="radio"/>	Asthma
<input type="radio"/>	<input type="radio"/>	High Blood Pressure
<input type="radio"/>	<input type="radio"/>	Back Problems
<input type="radio"/>	<input type="radio"/>	Dislocations. If yes, what joints? _____
<input type="radio"/>	<input type="radio"/>	Seizures
		If yes, what tends to trigger them? _____
		When did you last have a seizure? _____
<input type="radio"/>	<input type="radio"/>	Do you get cold easily?
<input type="radio"/>	<input type="radio"/>	Are you greatly affected by the heat?
<input type="radio"/>	<input type="radio"/>	Are you pregnant?
<input type="radio"/>	<input type="radio"/>	Are you allergic to any medication? If yes, what medications? _____

<input type="radio"/>	<input type="radio"/>	Are you allergic to any foods? If yes, what foods? _____

- | Yes | No | |
|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | Are you currently taking any medications?
If yes, what medication? _____ |
| <input type="radio"/> | <input type="radio"/> | Any side affects of the medication, such as fatigue or sensitivity to the sun?
If yes, what is the side affects? _____
_____ |
| <input type="radio"/> | <input type="radio"/> | Are you allergic to insect bites or stings?
If yes, what medication do you carry? _____
_____ |
| <input type="radio"/> | <input type="radio"/> | Do you have a disability?
If yes, please describe. _____
_____ |
| | | How long have you had the disability? _____ |
| <input type="radio"/> | <input type="radio"/> | Do you have mobility impairment?
If yes, please describe. _____
_____ |
| <input type="radio"/> | <input type="radio"/> | Do you have a sensory impairment (sight, sounds or sensation?)
If yes, please describe. _____
_____ |
| <input type="radio"/> | <input type="radio"/> | Do you tend to have muscle spasms or cramps? If yes, what tends to trigger
them? _____
_____ |

So that we can better understand your needs, please list any medical, physical, psychological or emotional issues not mentioned above. Also, feel free to write any additional comments or information you think is necessary or that would be valuable for us to know.

Please provide your health insurance information:

Company: _____

Group or other ID Number: _____

Insured person's name: _____

Phone number: _____

Emergency Contact:

Name: _____

Relation: _____ Phone: _____

Name: _____

Relation: _____ Phone: _____

Participant Signature:

Date: