

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 inoculation

Note: It is mandatory 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 Yes No

Asthma or hay fever? Yes No

Cardiovascular disease: heart trouble, heart attack Yes No

| | |
|--|--------|
| Coronary insufficiency or occlusion, arteriosclerosis, stroke | Yes No |
| Fainting spells or seizures | 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):

| | |
|--|--------|
| Antibiotics or sulfa drugs _____ | Yes No |
| Anticoagulants (blood thinners) _____ | Yes No |
| Antihistamines _____ | Yes No |
| Anti-inflammatories _____ | Yes No |
| Cortisone (steroids) _____ | Yes No |
| Digitalis or drugs for heart condition _____ | 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

Do you wear contact lenses Yes No

Have you had any serious trouble associated with previous dental treatment? Yes No

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.