

Participant Name _____ Course _____
E-mail _____ Course Date _____
Address _____
Day Phone _____ Cell Phone _____ Birth Date/Age _____
Emergency Contact: Name _____ Phone Number _____

Physical and Medical Questionnaire

ATS has compiled a physical and medical questionnaire. It is designed to provide information to your guide to help them make observations pertaining to the safety and well being of you and your group. Please be as complete as possible. Thank You.

What is your general physical condition? **Fair** **Good** **Very Good** **Excellent**

Describe your routine conditioning program _____

Have you had any of the following orthopedic complications: (If yes, please describe and specify approximate date)

Back Injury _____ Shoulder Dislocation _____ Hip Injury _____

Knee Injury or Surgery _____ Ankle Injury _____ Head injury? _____

Any other injury _____

Do you have a history with any of the following? (Specify date)

Epilepsy _____ Heart Disease _____ Diabetes _____

Emphysema _____ Pneumonia _____ Asthma _____

Are you currently taking any prescribed medications? (Please specify) _____

Are you allergic to any of the following?

Codeine _____ Penicillin _____ Sulfa Drugs _____

Bee Stings _____ Food _____ Other _____

Do you carry medications? Please specify: _____ Can you swim? _____

Do you wear prescription glasses or contact lenses? _____ Do you have hearing difficulties? _____

Do you have a fear of heights or exposed places? If yes, to what degree? _____

Can you hike long distances (6 miles a day) while wearing a 30 lb pack on and off trail? _____

Are there any other special restrictions or conditions we should know about? _____

I, _____ (participant's name), give permission to the medical personnel selected by ATS to provide routine health care; to transport me to the next level of medical care if required and administer medications. In the event that the emergency contact cannot be reached, I hereby give permission to the physician selected by ATS to secure and administer treatment, including hospitalization, for the person listed above.

Signed _____ Date _____

I, _____ (participant's name), hereby give permission for ATS to administer the following over-the-counter medications if ATS deems necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise.

Headache-Tylenol Upset Stomach-Pepto Bismol Menstrual Cramps-Ibuprophen
Diarrhea-Imodium AD Poison Ivy/Bee Stings-Calamine Lotion, Topical Lidocaine/Sting Kill
Signed _____ Date _____