

Health History / Personal Information

Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City: _____ State _____ Zip Code _____

E-mail: _____ Blood Type (if known): _____ Age: _____

Physician (name and phone number): _____

Health Insurance Provider: _____ Policy/ID Number: _____

Emergency Contact: _____ Phone: _____

MEDICAL HISTORY

Do you have any of the following conditions?

Cardiac problems	Yes	No
Chest pain	Yes	No
Chronic illness	Yes	No
Diabetes	Yes	No
High blood pressure	Yes	No
Stroke	Yes	No
Seizures	Yes	No
Back trouble	Yes	No
Joint problems/dislocations	Yes	No
Bleeding disorders	Yes	No
Shortness of breath/asthma	Yes	No
Blackout spells/dizziness	Yes	No
Pregnant NOW	Yes	No
Allergy to stings/bites	Yes	No
Muscle spasms	Yes	No
Mobility impairment	Yes	No
Sensory impairment	Yes	No
Learning disabilities	Yes	No
Do you get cold easily	Yes	No
Do you overheat easily	Yes	No
Other _____		

Please provide additional information for any "yes" answers noted previously. (Use attachment if necessary):

List prescription medications currently taking:

List non-prescription medications taken regularly:

List specific allergies and reactions:

Do you wear glasses/contacts?

How would you describe your general health?

What is your previous paddling experience?

Describe your swimming ability?

The information that you provide on this form is to assist your instructor in tailoring the class to your needs, and to aid emergency medical personnel in the event that you become ill or injured during a class. It will be kept confidential.

Photo & Media Release

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Participant Signature (or Guardian if under 18): _____ Date: _____