

Osprey Sea Kayak Adventures Inc.
Confidential Medical History Form

NAME: _____

ADDRESS: _____

CITY: _____

STATE: _____ ZIP: _____

PHONE: _____

DATE OF BIRTH: _____

Do you wear a medic-alert tag? Yes No
If so, for what condition(s)?

Do you have allergic reactions to any foods, drugs, insects, or other substances? Yes No

Are you hypoglycemic? Yes No

Are you a diabetic? Yes No

Have you ever had a heart attack or angina? Yes No

Do you have high blood pressure or other heart condition? Yes No

Do you have hemophilia? Yes No

Have you ever had a lung disease or breathing disorder? Yes No

Do you have any disabilities of back,hips,shoulders, knees or ankles? Yes No

When you walk for one mile at an average pace (12-20) minutes
Would you get out of breath, have chest or leg pain or get muscle fatigue? Yes No

Are you presently taking any prescription medication? Yes No
If yes, what type _____

Are you presently under the care of a physician? Yes No
If so for what condition? _____

Rate your swimming ability: Non Swimmer Beginner Intermediate Advanced

<p>IN CASE OF EMERGENCY, PLEASE CONTACT:</p> <p>NAME: _____</p> <p>PHONE NUMBER: _____</p>
