



VOLUNTEER MEDICAL FORM

PERSONAL INFORMATION

Name

First	Middle	Last
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Date of Birth

mm	dd	yyyy
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CONTACT INFORMATION

Email Address

Parent's Email, if under 18

HEALTH INFORMATION

Please list any current or past health issues, paying particular attention to limitations in ability to walk in rough terrain at an altitude of 2,011 m (6,600 ft), conditions that could possibly require immediate medical attention:

Please list what medications you take, if any:

Please list any past surgeries:

ALLERGIES

Please list any medical, environmental or food allergies:

DIET

Do you follow a special diet? If so, please provide the details below:

EMERGENCY CONTACTS

If applicable, please list contact information for pertinent doctors in case of emergencies:

Please list emergency family contact information:

Do you have or plan to purchase travel medical insurance, including emergency evacuation?

Yes No

If yes, please provide the name and number of the provider if available.