



GENERAL INFORMATION

Name _____ Date of Birth _____
 Address _____
 City _____ State _____ Zip _____
 Home Phone _____

EMERGENCY INFORMATION

In case of emergency, notify:
 Name _____ Relationship _____
 Address _____
 Home Phone _____ Other way to reach this person _____

MEDICAL INFORMATION

Have you had (Mark "past" or now or leave blank)

	Past	Now		Past	Now
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	Severe stomachaches	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Earache/ear infection	<input type="checkbox"/>	<input type="checkbox"/>	Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>			

Other allergies or reactions to any medication _____
 Do you tire easily? _____
 Have you had more than a brief minor illness? _____
 Have you had an injury in the past year? _____
 If so, what? _____
 Any condition now require any regular medication or treatment? _____
 If so, what? _____
 Operations or serious injuries (dates) _____
 Any restrictions of activity for Medical reasons _____

BACKGROUND INFORMATION

(A - Unfamiliar with B - Have knowledge of C - Have experience in
 D - Have instructed)

	A	B	C	D		A	B	C	D
Backpacking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Canoeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Land Navigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rafting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Winter Camping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Water Rescue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rock Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cliff Rescue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rappelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cave Rescue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fire Rescue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wilderness survival	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(A - Very uncomfortable B - Moderately comfortable C - Comfortable)

	A	B	C		A	B	C
Height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Closed in places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Darkness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you participated in any of my courses before? _____ If so when _____

What other outdoor conference, school or course have you participated in? _____
 If you are member or past member of any outdoor related organization, please list them. _____
 Who recommended this course to you? _____
 Whats your main objectives for enrolling in this course? _____

Information above is correct to the best of my knowledge.

Date _____, Signed _____
 Applicant