

**DISCOVERY ADVENTURES BAJA EXPEDITION 2007
REGISTRATION & HEALTH HISTORY**

Name: _____ Age _____ Sex: M F

Address: _____

Phone (home) _____ (work) _____ (cell) _____

Emergency Contact: _____ Phone: _____

Height: _____ Weight: _____ E-mail address: _____

TOTAL PAYMENT DUE \$ _____ DEPOSIT AMOUNT \$ _____ BALANCE DUE \$ _____

Health information on this form is not part of the acceptance process, but is gathered to assist us in identifying appropriate care. Discovery Adventures reserves the right to cancel trips and reschedule due to extreme weather or unforeseen circumstances. We have the right to remove anyone from the program for inappropriate behavior without refund.

HEALTH HISTORY (check – give approx. dates if applicable)

- Frequent Ear Infections
- Heart Defect/Disease
- Seizures
- Diabetes
- Asthma
- Bleeding/Clotting Disorders
- Hypertension
- Mononucleosis
- Chicken Pox
- Measles
- German Measles

- Allergies: No Yes Please Specify: _____
- Hay Fever
- Insect Stings
- Penicillin
- Other drugs _____
- Poison Ivy, Oak, Sumac
- Foods – Specify if checked
- Other _____

Recent Surgeries or Serious Injuries (dates): _____

Chronic/Recurring Injuries/Illnesses: _____

Current Medications? NO YES Medication type: _____

For what condition/illness is medication used? _____

The Discovery Adventures Program is equipped with first aid kits that include the following over-the-counter medications which are approved by our consulting physician, Dr. John Wolfe. At least one staff member is EMT-B certified and is present. In the event of illness or injury, these medications are available for administration by staff members only. Please check and initial to approve the use of:

- Ibuprofen Non-Aspirin(Tylenol) Diphenhydramine (Benadryl, antihistamine) Pepto-Bismol
- Dramamine (non-drowsy, for motion sickness)

Name of Family Physician: _____ Phone: _____

Insurance Provider & Plan #: _____

Authorization for Treatment: I hereby give permission to the medical personnel to administer treatment and/or authorized medications and arrange necessary related transportation in the event of an illness or injury. I hereby give permission to the physician to secure and administer treatment, including hospitalization.

Signature: _____ **Date:** _____