



LAKETRAILS BASE Camp

Trip Dates: _____

Before June 1st, please mail to:

Laketrails Base Camp
P.O. Box 810
Warroad, MN 56763

June 1st or later, please mail to:

Laketrails Base Camp
P. O. Box 25
Oak island, MN 56741

CONFIDENTIAL HEALTH FORM FOR CANOE TRIPS

This form is essential for participant's safety. Please fill it out completely.

NAME _____ BIRTH DATE _____ GENDER _____

ADDRESS _____
(No. and Street) (City) (State) (Zip)

PHONE NO. _____

DOCTOR/CLINIC _____ CLINIC PHONE NO. _____

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____

EMERGENCY CONTACT PHONE NO.: _____

HEALTH INSURANCE CARRIER _____ POLICY # _____

HEALTH HISTORY

Please indicate your history of the following: (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Asthma | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Toothaches | <input type="checkbox"/> Abnormal Blood Pressure |
| <input type="checkbox"/> Kidney/Bladder Problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Sight or Hearing problems | <input type="checkbox"/> Any not listed here | |

If "yes" to any of the above, please explain: _____

Immunization History: Date of last Tetanus vaccination: _____

Are you currently taking any medication? If yes, list medication, dose, frequency & reason for taking:

NOTE: All medications brought to camp must be in original containers and with instructions for use.

Please indicate any allergies: (check all that apply)

- | | | | |
|-------------------------------------|-----------------------------------|--|--------------------------------|
| <input type="checkbox"/> Insects | <input type="checkbox"/> Clothing | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Other |
| <input type="checkbox"/> Poison Ivy | <input type="checkbox"/> Food | <input type="checkbox"/> Other Medications | |

If "yes" to any of the above, please describe the allergic reaction and how it is treated: _____

Please list any significant injuries or conditions that could affect your ability to participate in a wilderness canoe trip.



LAKETRAILS BASE CAMP

The individual listed below will be participating in a strenuous camping program including a five-day wilderness canoe trip that entails several hours of paddling each day and lifting and carrying canoes and/or packs weighing from 40-80 lbs. Loading and unloading canoes often takes place on wet, slippery, and rocky surfaces. It is important that Laketrails be made aware of any health conditions that would hinder the participant's full involvement in the Laketrails program.

_____ has been examined by a physician within the past 12 months.
(Name)

___YES ___NO

DATE OF LAST EXAM: _____

HEIGHT _____

WEIGHT _____

PARTICIPANT'S AUTHORIZATION:

I certify that the health information I have provided to Laketrails Base Camp is correct as far as I know.
This completed form may be photocopied to take on the canoe trip.

PARTICIPANT'S SIGNATURE: _____

DATE _____

For office use:

Reviewed: _____ Date: _____
(Camp Health Manager)