



# LAKETRAILS BASE Camp

Trip Dates: \_\_\_\_\_

**Before June 1<sup>st</sup>, please mail to:**

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

**June 1<sup>st</sup> 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

PHYSICIAN IS ASKED TO COMPLETE THIS PORTION OF THE FORM

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 within the past 12 months.  YES  NO  
(Name)

DATE OF EXAM: \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_

SIGNIFICANT PAST HISTORY: YES  NO  IF YES, EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CURRENT MEDICAL PROBLEMS: YES  NO  IF YES, EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_

ANY ABNORMALITIES ON PHYSICAL EXAM OR LAB REPORT: YES  NO  IF YES, EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_

SPECIAL RECOMMENDATIONS: YES  NO  IF YES, EXPLAIN: \_\_\_\_\_  
\_\_\_\_\_

I have examined the above individual and have reviewed his/her health history. I conclude that he/she can participate in the canoe trip as described except as noted above.

**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ **DATE** \_\_\_\_\_

### 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)