ISLAND ESCAPADES PROGRAM AND MEDICAL FORM

118 Natalie Lane, Salt Spring Island, V8K-2C6 1-888 -529-2567

This form must be completed and returned to us at least 30 days before your trip departure date. Disclosures made on this form and all information is completely confidential. Please print in ink.

Full Legal Name: _____ **Medical Number**: _____

Age: _____ Birthday: _____ Gender: _____

Your TRAVEL / MEDICAL/ EVACUATION INSURANCE POLICY (if applicable)
Name of plan: _____ Name of company providing plan:_____
Phone number to call to activate plan:_____ Your plan's reference number:_____

Do you have any dietary restrictions? (All meals are vegetarian, other than seafood) YES NO
If yes, please describe: _____
_____
_____
_____
Do you have any known allergies or have you ever had a severe allergic reaction?
YES NO
If YES, please describe what causes reaction, what happens and any additional medication you may carry for this condition:
_____
_____
_____

Do you have a current **Tetanus** inoculation or booster Yes_____ No____
If yes, please list when the shot was given: Month _____Year_____

Please list all medical conditions (heart disease, diabetes, etc.), psychological and physical conditions (seizure disorders, depression, bad back, joint problems, etc.) that may affect your ability to participate in the program you have registered for.
(Circle) Frostbite Pregnancy Tendonitis /ligaments Hyperthermia Hypothermia Previous knee problems Blister problems Infection problems Other

Please describe all past and present problems, how they affect you, what are the symptoms of onset, and what brings them on:
_____
_____
_____
_____
Please list any medications, both prescription and nonprescription, that you will be bringing with you on your program. Please list the name of the medication, the reason it is taken, the instructions for frequency and dosage._____
_____
_____
_____
How long does the medication take to become effective?_____
Are there any side effects from the medication?_____
Do you need assistance taking your medication?_____

PLEASE, IF YOU ARE BRINGING MEDICATION WITH YOU:
List detailed dosage and frequency instructions on the outside of each container. Include the name of the drug as well. Bring twice as much as you are required to take for the entire length of your program with us, in two separate containers (sun/waterproof). Give half to your guide or instructor in case you lose your own. *** Make sure it has not expired***

Our objective is to provide a fun, safe and supportive environment, which will give participants a rewarding experience. Our instructors will strive to familiarize you with ocean kayaking, strokes and rescues, tides and currents, and wildlife. We also hope to teach you about the diverse life beneath the ocean waters. Our aim is to encourage low impact camping and out-door awareness within the group.
To make this adventure more enjoyable for all, please share with us any other objectives, questions or fears that concern you.

_____
_____
_____

On your program there will be many new and unfamiliar experiences. We would like to know your confidence level with the following:

SWIMMING	**(very uncomfortable)**	1	2	3	4	5	6	7 **(very comfortable)**
WILDERNESS CAMPING		1	2	3	4	5	6	7
USING OUTDOOR TOILETS		1	2	3	4	5	6	7
EXTENDED EXERCISE		1	2	3	4	5	6	7

NAME AND NUMBER OF PERSON TO CALL IN CASE OF EMERGENCY:
First choice name: Relationship:
Home phone: ( ) Best time to reach at this number?
Work phone: ( ) Best time to reach at this number?
Second choice name: Relationship:
Home phone: ( ) Best time to reach at this number?
Work phone: ( ) Best time to reach at this number?
Physicians name: _____ **Phone #**_____

CONSENT FOR MEDICAL TREATMENT OF AN UNDER AGE PARTICIPANT

NAME OF PROGRAM: _____ PROGRAM DATES: _____
MEDICAL #: _____
In the case of the participant being under nineteen (19) in the Province of British Columbia, or under the age of responsibility elsewhere, I hereby give permission to a trip representative to arrange for any medical treatment required by my child or ward while he/she is under the care of the chaperone or guide during the program named above. Also, _____(optional) can pick up this child with the CODE WORD_____. (If the parent is not picking the child up, whoever is, must use this code word, or custody won't be granted.) I give my consent to Island Escapades guides to administer any medication to my child/ ward (if they are under the age of 19).

Parent/Legal Guardian Signature Date Participants Name
_____ _____ _____
_____

I have completed this medical/program form accurately and truthfully, to the best of my knowledge. I understand that any injury or illness that is aggravated by, or a result of my participation in this program and any evacuation cost arising thereof, is solely my own responsibility and I hereby release Island Escapades Ltd. and its directors, management, employees, and associates from any future claims I might make against them. I understand that it is my responsibility to inform Island Escapades before my program begins, of any medical conditions that may have arisen after filling out this form. Signed this _____ day of _____, 2017.

Participants Signature **Witness Signature** **Parent/Guardian Signature** (if applicable)

_____ _____ _____

Fax to: 250 537-2532 Mail to: Island Escapades, 118 Natalie Lane, Salt Spring Island, B. C. V8K-2C6