CONFIDENTIAL HEALTH QUESTIONNAIRE

DATE:_____ NAME AND DATES OF PROGRAM: _____

NAME:_____ AGE: _____ E-MAIL: _____

ADDRESS: _____

CELLPHONE (for use on day of group's arrival): _____ HOME PHONE: _____

FOR EMERGENCY USE:

Your doctor's name: _____ Phone number: _____

Medical Insurance Co.:_____ Group/Policy No.: _____

In case of emergency, notify: Name:_____ Relationship: _____ Phone: _____

Does your doctor know you are going to participate in this retreat: Yes No

Does your emergency contact person know you will participate: Yes No

1.	Are you under the care of a physician? Have you described this program to your physician and discussed your plans to participate? Does your physician approve of you participating? Please describe any discussions you've had: _____ _____ _____	Yes No Yes No Yes No
2.	Are you seeing a therapist at present? Would your therapist disapprove of you entering this activity? If yes, please describe why: _____ _____	Yes No Yes No
3.	Do you have any history of emotional or psychological problems? If yes, please describe: _____ _____ Please list any medications you are taking for psychological problems: _____ _____	Yes No
4.	Are there any reasons why you should not fast or live alone? If yes, please describe: _____ _____	Yes No
5.	Do you wear a Medic-Alert Tag or any other marker of a medical problem? If yes, please describe: _____ _____	Yes No
6.	Were you hospitalized in the last two years? If yes, please describe: _____ _____	Yes No
7.	Have you ever had a heart attack of any kind, or been told by a doctor that you have high blood pressure, a heart murmur or heart disease? If yes, please describe: _____ _____	Yes No

8.	Have you ever experienced a seizure of any kind? If yes, please describe: _____ _____	Yes No
9.	Do you have allergic or anaphylactic reactions to any insults, such as environmental substances, foods, drugs, insect bites or stings? If yes, please describe (including medications you carry for exposures): _____ _____	Yes No
10.	Do you have hemophilia or any other disorder that impairs blood-clotting? If yes, please describe: _____ _____	Yes No
11.	Do you have a lung disease or any kind of breathing problem? If yes, please describe: _____ _____	Yes No
12.	Do you have any muscle, joint, or bone related disabilities? If yes, please describe: _____ _____	Yes No
13.	Do you have trouble with headaches? If yes, please describe: _____ _____	Yes No
14.	Do you have any kidney disease? If yes, please describe: _____ _____	Yes No
15.	If you walked on the level for a mile at an average pace would you get out of breath, have pains in the chest, develop muscle fatigue or have pains in your legs? Describe your degree of fitness in your own words:_____ _____	Yes No
17.	Do you have hypoglycemia or diabetes? If yes, please describe: _____ _____	Yes No
18.	Do you have any other chronic disease that, in any way, threatens your health? If yes, please describe: _____ _____	Yes No
19.	Are you taking <u>any</u> medication at the present time? If yes, specify each drug, the dose and the reason for taking: _____ _____ _____ _____	Yes No
20.	Any dietary preferences or needs? If yes, please describe: _____	Yes No
21.	When was your last tetanus shot? _____	

This information is accurate and complete. I agree to cooperate with the retreat facilitators to design a wilderness practice with full consideration of my health history and health concerns. I give my permission to the School of Lost Borders guides on this trip to seek emergency medical diagnosis or treatment for me in the event that I am unconscious or unable to make my own decisions. Our role in offering medical treatment will be limited to emergency first-aid and either transportation to the nearest medical facility, or contacting such a facility to arrange emergency transport.

SIGNATURE: _____

(If under 18 years old, must be parent or guardian's signature)