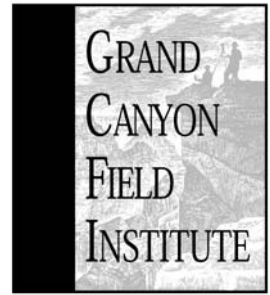


Confidential Health Questionnaire



As a part of our ongoing efforts to evenly match participants with each class, we are asking all registrants to send their answers to the questions below when enrolling in any class. Your responses will remain confidential. Your participation is subject to our receipt of this form and approval by GCFI staff or the instructor.

Physical Condition—Describe your regular exercise activities.

Backpacking Experience (*if any*)—Please provide the following information about relevant outing experience in the last few years (particularly desert and high-altitude hiking):

Dates and locations, distances hiked (total and longest day), total elevation gain and loss, and maximum weight carried.

Climbing Experience (*to be completed by those attending a Wilderness Studies Workshop level 6 or higher*) -- Please provide details about any climbing courses you may have attended or routes (including class) you might have completed.

Medical Information (*please* be forthright as you complete this section—for your protection and that of others)

1. Name Mr. Mrs. Ms. _____

2. Course Name & Date _____ 3. Occupation _____

4. Birth Date _____ 5. Contact Phone _____ 6. Height _____ Weight _____

7. Address _____

8. Doctor's Name _____ Phone _____

9. Emergency Contact _____ Relationship _____
 Phone (day) _____ (eve) _____ Email _____

10. Are you covered by any hospitalization/care policy? Yes ____ No ____ Policy # _____

11. Insurance Company Name and Address _____

12. Does your insurance company require pre-authorization? Yes ____ No ____ If yes, phone # _____

13. ARE YOU CURRENTLY EXPERIENCING OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	Yes	No		Yes	No
Heart problems/attack	___	___	Overweight	___	___
Chest pain/pressure	___	___	Currently pregnant	___	___
Frequent shortness of breath	___	___	Asthma/respiratory problems	___	___
Frequent dizziness	___	___	Diabetes/blood sugar problems	___	___
Frequent fainting	___	___	Recurrent/frequent headaches	___	___
High blood pressure	___	___	Ulcer/stomach problems	___	___
Depression/anxiety	___	___	Urinary tract problems	___	___
Smoker	___	___	Musculo-Skeletal problems	___	___
Hepatitis	___	___	Hospitalization/surgery (within the last year)	___	___
Seizures	___	___	HIV Positive	___	___
			Other _____		

If you answered "Yes" to any of the above, you must provide a note from your doctor showing that he/she has cleared you for the class. Without such written clearance you will not be permitted to participate.

14. List any allergies/anaphylaxes (including medications, foods, bites, and stings).

15. List all your current medications (including over-the-counter drugs). Conditions such as sun exposure and high temperatures or cold water immersion **may require a re-calibration of your current dosage**. We encourage you to **consult with your physician** if you are taking any medication. Please bring two (2) courses of your medication. Be sure to remind your instructor what medications you are currently taking and their purpose.

Medication	Purpose	Medication	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

16. Your Signature _____ Date _____