# Travel and Fitness Medical Waiver Form

**Please fill all fields accurately**

| | | | |
|---|---|---|---|
| First Name: | | Last Name: | |
| Address: | | City: | |
| | | | |
| Province/State: | | Postal/Zip Code: | |
| Email: | | Phone: | |
| Height: | | Weight: | |

**Medical Information**

| | | | |
|---|---|---|---|
| Primary Practitioner or Physician: | | Phone: | |
| Address: | | City: | |
| | | | |
| Province/State: | | Postal/Zip Code: | |

| Existing Medical Conditions - Please check appropriate box | | | |
|---|---|---|---|
| ☐ | Diabetes | ☐ | Ulcers |
| ☐ | Anemia | ☐ | Cancer |
| ☐ | Cardiovascular Disease | ☐ | Arthritis |
| ☐ | High Cholesterol | ☐ | Musculoskeletal Disorder |
| ☐ | Multiple Sclerosis | ☐ | Hypertension |
| ☐ | Osteoporosis | ☐ | Pre/Post Natal |
| ☐ | Hypothyroidism | ☐ | Hyperthyroidism |
| ☐ | Digestive Disorders | ☐ | Neurological Disorders |
| ☐ | Other: | | |

| Family History - Please check appropriate box | | | |
|---|---|---|---|
| ☐ | Diabetes | ☐ | Ulcers |
| ☐ | Anemia | ☐ | Cancer |
| ☐ | Cardiovascular Disease | ☐ | Arthritis |
| ☐ | High Cholesterol | ☐ | Musculoskeletal Disorder |
| ☐ | Multiple Sclerosis | ☐ | Hypertension |
| ☐ | Osteoporosis | ☐ | Pre/Post Natal |
| ☐ | Hypothyroidism | ☐ | Hyperthyroidism |
| ☐ | Digestive Disorders | ☐ | Neurological Disorders |
| ☐ | Other: | | |

**Medications**

| | | | |
|---|---|---|---|
| Are you currently taking medications? | ☐ Yes ☐ No | If yes, please list all medications: | |
| Do you have any allergies? | ☐ Yes ☐ No | If yes please list all allergies (including insect allergies): | |

**Pain and Injury**

| | | | |
|---|---|---|---|
| Have you suffered any injuries in past year? | ☐ Yes ☐ No | If yes, please list all injuries: | |
| Have you had any surgeries in the past year? | ☐ Yes ☐ No | If yes please list all surgeries: | |
| Any other physical pain? | ☐ Yes ☐ No | If yes, please list pain (in detail): | |

**Please complete questionnaire**

| | | | |
|---|---|---|---|
| Do you experience chest pain? | ☐ Yes ☐ No | Are you a smoker? | ☐ Yes ☐ No |
| Have you had any recent severe infections? | ☐ Yes ☐ No | Can you swim? | ☐ Yes ☐ No |
| Have you suffered any recent head injuries? | ☐ Yes ☐ No | Are you currently in an active exercise program? | ☐ Yes ☐ No |
| Do you experience dizziness? | ☐ Yes ☐ No | Do you have any special dietary restrictions? | ☐ Yes ☐ No |
| Do you have any water or height phobias? | ☐ Yes ☐ No | Do you have | ☐ Yes ☐ No |
| Do you lose consciousness easily? | ☐ Yes ☐ No | Any other physical pain? | ☐ Yes ☐ No |

By signing below, I hereby verify that all information on this form is **true** and **correct** to the best of my knowledge,

_____ _____

Signature of Participant Date

_____ _____

Signature of Parent/Legal Guardian if Participant is under 18 years of age (must be at least 25 years of age to sign) Date