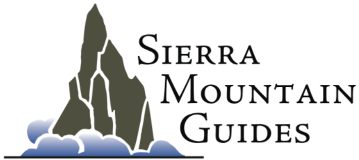

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Medical Information Form

Many of our programs take place in remote settings where rescue is difficult and definitive medical care is far away. Additionally, most of our outings require a relatively high level of physical activity for a considerable length of time. We will use the information on this form to help you choose an appropriate program and to facilitate medical care should a problem arise. Thank you for taking the time to thoroughly and accurately answer all of the questions on this form. It can be filled out electronically or printed and mailed/faxed to our office. If we have any questions about your ability to safely complete a program we will contact you to discuss it. You may be asked to consult a physician. All information on this form is kept in strict confidence by SMG guides and staff. Thank you for helping us provide you the safest and most enjoyable mountain experiences possible!

Your Name: First M.I. Last

Name of Trip/Program: | Date(s):

Date of Birth: | Height:

Gender: Male Female | Weight:

Primary phone #: | Secondary phone #:

Email Address:

Emergency Contact: Relationship to you:

Primary phone #: Secondary phone #:
Email address:

If this is a program where food is provided, do you have any special dietary needs, preferences, or aversions?

For your convenience, we rent some technical gear for our programs.
Will you need to rent any equipment from SMG? Yes No
If yes, what?

Briefly describe your physical conditioning program and your general fitness level:

Physicians Name: | Physician's Phone #:

Your health insurance provider: | Policy #:

We do not provide medical insurance. You are expected to have your own current policy when you sign up for a trip/program. Unless otherwise stated, rescue insurance is not included. Membership in the American Alpine Club includes rescue insurance and is recommended. See www.americanalpineclub.org for details.

Medical History: Do you now have, or have you had within the past three years, any of the following conditions? If "yes" to any of the conditions below, please explain in the space provided.

Condition	Yes	No	Condition	Yes	No
Altitude Illness			Diagnosed Mental Illness		
Broken Bones			Severe Anxiety or Depression		
Severe Sprains			High Blood Pressure		
Shoulder or Neck Problem			Heart Disease		
Back Problem			Seizure Disorder		
Foot or Ankle Problem			Asthma		
Leg or Knee Problem			Diabetes		
Arm or Hand Problem			Chronic Headaches		
Intestinal Problem			Shortness of Breath		
Urinary Tract Problem			Chest Pain		
Heat or Cold Intolerance			Hospitalization in Past Year		
Uncorrected Vision or Hearing Impairment			Women only: Are you currently pregnant?		

Please elaborate on any "Yes" response from above:

Are you currently taking any prescription medications? If yes, please list medications and dosage.

Are you allergic to any foods, insect bites, medications, or other? If yes, please explain what you are allergic to, the reaction, and treatment required.

Do you have any other condition that could affect your performance during physical activity, including your ability to run, lift, climb, or ski? If yes, please describe.

Please describe your background in relevant outdoor activities:
Rock/ice climbing, skiing, backcountry skiing, mountaineering, wilderness hiking, gym climbing etc...

All of the information given to Sierra Mountain Guides on this form is complete and accurate to the best of my knowledge.

Participant Initials: ______________

Initials of Parent/Guardian (if participant is under age 18): ______________