

please complete both sides!

The National Park Service **REQUIRES** Canyoneers to obtain full legal name (first, middle, and last), date of birth (month, day, & year), medical history, medications presently taking, and the reason for taking the medications from **EACH** participant. Canyoneers and its officers and employees do not screen prospective river passengers based on medical information provided. It is up to the prospective passenger and his/her physician to determine whether or not he/she is physically/mentally able to participate in a Grand Canyon river trip. All information is confidential and will in no way eliminate you from the river trip for which you are reserved. This information is required so we are aware of any potential health problem that might affect your experience on the river. Participants **MUST DECLINE IN WRITING** if they choose not to provide the medical information.

**Personal/ Medical Information**

return immediately to

**Canyoneers, Inc**

**PO Box 2997 ~ Flagstaff AZ 86003**

**fax 928-527-9398 or email answers@canyoneers.com**

**Personal Information — Please print carefully**

Full Legal Name (first & last) as required by the National Park Service

Name \_\_\_\_\_ Date of Birth (m/d/y) \_\_\_\_\_

Trip type/length \_\_\_\_\_ Trip date \_\_\_\_\_

In accordance with the National Park Service "One Trip per Year" mandate, I certify I have not, nor will not, participate on more than one recreational river trip through any part of the Grand Canyon from Lees Ferry to Diamond Creek of the Colorado River this calendar year.

\_\_\_\_\_ (please sign & date)

Preferred name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

St \_\_\_\_\_ ZIP \_\_\_\_\_ Ctry \_\_\_\_\_

Telephone \_\_\_\_\_

e-mail \_\_\_\_\_

Emergency Contact (relative/friend not on trip with you)

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Telephone (hm/wk) \_\_\_\_\_

Physician's Name \_\_\_\_\_

Physician's Telephone \_\_\_\_\_

I DECLINE to provide the requested medical information as required by the National Park Service

signature \_\_\_\_\_ date \_\_\_\_\_

# please complete both sides!

Name (wish to go by) \_\_\_\_\_ Trip type/length \_\_\_\_\_

Date of Birth (m/d/y) \_\_\_\_\_ Trip date \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Hgt \_\_\_\_\_ Wgt \_\_\_\_\_ Chest measurement (for proper life jacket fit) \_\_\_\_\_ "

## Please check all that apply to you

- Tents are 2 person tents. However, I wish to have a separate tent for myself only
- I am vegetarian, but I eat poultry and/or fish (vegetarian meals NOT available at Phantom Ranch)
- I am a strict vegetarian
- no dairy products
- I need gluten free
- I have special physical accommodation needs (please attach specific details)

## Medical History (required by the National Park Service)

### Please describe in detail, print carefully

(attach separate paper if more space is needed)

Preexisting &/or chronic ailment(s) or disease(s)

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Present medication (type, reason for taking)

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Previous injuries/surgeries & year

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Allergies (be specific)

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## Medical History—Please mark all that apply

### past present

- ADD, ADHD, Autism
- Mental Retardation
- Acrophobia
- Anxiety Reaction
- Allergic to bee stings/insect bites
  - I will bring my own epi pen
- Amputee, body portion \_\_\_\_\_
- Anemia
- Arthritis/Osteoporosis or Joint Disorders
  - moderate  severe, specify \_\_\_\_\_
- Gout
- Asthma
- Emphysema
- Respiratory Disorder
- Tuberculosis
- Bleeding Disorders
- High Blood Pressure
- Low Blood Pressure
- Cancer, specify \_\_\_\_\_
- Leukemia
- Hodgkin's
- Cerebral Palsy
- Cystic Fibrosis
- Diabetes  insulin required (cooling available)
- Hypoglycemic

### past present

- Epilepsy
- Glasses/Contacts
- Glaucoma
- Hearing Loss  moderate  severe  
specify \_\_\_\_\_
- Heart Disorder, specify \_\_\_\_\_
- Angina
- Arrhythmia
- Stroke
- Hepatitis type \_\_\_\_\_
- HIV/AIDS/ARC
- Intestinal Disorders
- Ulcer
- Kidney Disease
- Migraines
- Multiple Sclerosis
- Paralysis, body portion \_\_\_\_\_
- Parkinsons
- Polio
- Pregnant
- Rheumatic Fever
- Sinus Condition/Allergies
- Sleepwalker
- Thyroid Disease
- Other, specify \_\_\_\_\_

over please