

## PERSONAL INFORMATION

The logistics of wilderness and backcountry travel necessitate being a long way from hospitals, doctors, and pain-relieving medications. Because of the environmental and physical challenges that are inherent in wilderness travel, most trips are accompanied by a Certified Wilderness First Responder. Depending on the location, evacuation to a medical facility may be complicated, protracted, and expensive. In the event of illness or injury, and to provide appropriate emergency care, we need to be aware of any pre-existing medical or health conditions you may have that could be aggravated as a result of this experience. We do have on board an AED unit. We respectfully urge you to be as thorough as possible in providing the information requested. Be sure to read both sides of this form.

All information will remain confidential. We sincerely thank you for your cooperation.

| CONTACT INFORMATION |        |                |
|---------------------|--------|----------------|
| NAME:               |        |                |
| ADDRESS:            |        |                |
| CITY:               | STATE: | ZIP:           |
| PHONE:              | FAX:   | EMAIL ADDRESS: |

| IN CASE OF AN EMERGENCY  |              |                    |
|--|--------------|--------------------|
| NAME OF PERSON TO BE NOTIFIED IN CASE OF AN ILLNESS OR INJURY: |              |                    |
| RELATIONSHIP TO YOU:   |              |                    |
| ADDRESS:   |              |                    |
| CITY:  | STATE:       | ZIP:               |
| PHONE:   | FAX:         | WORK PHONE:        |
| YOUR PHYSICIAN'S NAME:   |              | PHYSICIAN'S PHONE: |
| BIRTHDATE:   | YOUR WEIGHT: | YOUR HEIGHT:       |

| FOOD RESTRICTIONS   |  |                                   |                                    |                                    |  |  |  |  |
|---|--|-----------------------------------|------------------------------------|------------------------------------|--|--|--|--|
| DO YOU HAVE ANY SPECIAL DIETARY RESTRICTIONS? IF SO, PLEASE CHECK ANY OF THE FOLLOWING:<br>(WE ARE NOT SPEAKING OF FOOD PREFERENCES, BUT OF DIETARY RESTRICTIONS)   |  |                                   |                                    |                                    |  |  |  |  |
| <table><tr><td><input type="checkbox"/> HYPOGLYCEMIC</td><td><input type="checkbox"/> LOW-FAT</td><td><input type="checkbox"/> DIABETIC</td><td><input type="checkbox"/> NON-DAIRY</td></tr><tr><td><input type="checkbox"/> VEGETARIAN— PLEASE NOTE WHAT YOU DO EAT (DAIRY, EGGS, ETC.)</td><td colspan="3"><input type="checkbox"/> OTHER, PLEASE DESCRIBE:</td></tr></table> | <input type="checkbox"/> HYPOGLYCEMIC            | <input type="checkbox"/> LOW-FAT  | <input type="checkbox"/> DIABETIC  | <input type="checkbox"/> NON-DAIRY | <input type="checkbox"/> VEGETARIAN— PLEASE NOTE WHAT YOU DO EAT (DAIRY, EGGS, ETC.) | <input type="checkbox"/> OTHER, PLEASE DESCRIBE: |  |  |
| <input type="checkbox"/> HYPOGLYCEMIC   | <input type="checkbox"/> LOW-FAT                 | <input type="checkbox"/> DIABETIC | <input type="checkbox"/> NON-DAIRY |                                    |  |  |  |  |
| <input type="checkbox"/> VEGETARIAN— PLEASE NOTE WHAT YOU DO EAT (DAIRY, EGGS, ETC.)  | <input type="checkbox"/> OTHER, PLEASE DESCRIBE: |                                   |                                    |                                    |  |  |  |  |

PERSONAL INFORMATION

PACIFIC CATALYST II, INC.  
PO BOX 3117, FRIDAY HARBOR, WA. 98250

**MEDICAL INFORMATION**

*To help us understand and assess any medical problems that might arise during your trip, please comment on the following details of your recent medical history*

ALLERGIES (FOODS, MEDICINES, INSECT STINGS, ETC.):

IF SEVERELY ALLERGIC, DO YOU CARRY AN ANA-KIT FOR EMERGENCY TREATMENT? YES                      NO

HAVE YOU BEEN HOSPITALIZED FOR SEVERE ILLNESS OR SURGICAL PROCEDURES DURING THE PAST TWO YEARS? IF SO, DESCRIBE AND PROVIDE APPROXIMATE DATE(S).

PLEASE INDICATE ANY POTENTIAL HEALTH PROBLEMS IDENTIFIED BY YOUR PHYSICIAN:  
DIABETES                      HEART                      RESPIRATORY                      EPILEPSY/SEIZURES  
OTHER, PLEASE DESCRIBE:

HAVE YOU HAD A TETANUS BOOSTER WITHIN THE PAST 7 YEARS? YES                      NO

DO YOU HAVE HIGH BLOOD PRESSURE? IF YES, PLEASE DESCRIBE.

DO YOU HAVE PALPITATIONS OF THE HEART, AN IRREGULAR HEARTBEAT, HEART MURMUR, OR POOR CIRCULATION? IF YES, PLEASE DESCRIBE.

ANY RECENT BROKEN BONES, SERIOUS SPRAINS, OR DISLOCATIONS? IF YES, PLEASE DESCRIBE.

PLEASE LIST YOUR PRESCRIPTIONS AND MEDICATIONS AND DESCRIBE THEIR PURPOSE. PLEASE INCLUDE DOSAGE INFORMATION IF POSSIBLE.

I hereby consent to any emergency care, hospital care, medical or surgical diagnosis and/or treatment to be rendered to me as found advisable for any injuries that may arise from my participation in a Pacific Catalyst trip. I understand and agree that I am solely responsible for all applicable charges for such medical treatment, evacuation, and rescue. This medical information form is filled out completely and accurately, to the best of my knowledge.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PARTICIPANT SIGNATURE OR PARENT/GUARDIAN IF UNDER 18  
FOR IP/GBRF/TRANSIT THROUGH BC, CANADA: GUESTS:

PASSPORT # :

COUNTRY/ST/CITY/ISSUED:

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