

# OSPREY SEA KAYAK ADVENTURES

## CONFIDENTIAL MEDICAL HISTORY

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

Do you wear a medical alert tag? Yes  No   
If so, what for? \_\_\_\_\_

Do you have allergic reactions to any food, drugs, insects, plants,  
or other substances? Yes  No   
Please explain: \_\_\_\_\_

Are you hypoglycemic? Yes  No

Are you diabetic? Yes  No

Have you ever had a heart attack or angina? Yes  No

Do you have high blood pressure or other heart condition?  
Please explain? \_\_\_\_\_

Do you have hemophilia? Yes  No

Have you had a long disease or breathing disorder?  
Please explain: \_\_\_\_\_

Do you have any disabilities of the back, hips, shoulders, knees,  
or ankles? Yes  No   
Please explain: \_\_\_\_\_

Are you presently taking any prescription medication? Yes  No   
If yes, what type? \_\_\_\_\_

Are you presently under the care of a physician? Yes  No   
If so for what condition? \_\_\_\_\_

Rate your swimming ability:  
Non Swimmer  Beginner  Intermediate  Advanced

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_