EARTHWAYS LLC CONFIDENTIAL HEALTH QUESTIONNAIRE

DATE:________________ NAME AND DATES OF PROGRAM: ______________________________________

NAME:____ AGE: _____ E-MAIL: ____________________

ADDRESS: ____

CELLPHONE (for use on day of group's arrival): ___________________ HOME PHONE: ____________________

FOR EMERGENCY USE:

Your doctor's name: _________________ Phone number: ________________

Medical Insurance Co.:______________________________________ Group/Policy No.: ___________________

In case of emergency, notify: Name:________________ Relationship: _____________ Phone: ________________

Does your doctor know you are going to participate in this retreat: ☐ Yes ☐ No

Does your emergency contact person know you will participate: ☐Yes ☐ No

1.	Are you under the care of a physician?	□ Yes □ No
	Have you described this program to your physician and discussed your plans to participate?	□ Yes □ No
	Does your physician approve of you participating?	□ Yes □ No
	Please describe any discussions you've had: ____________________________________ ____ ____	
2.	Are you seeing a therapist at present?	□ Yes □ No
	Would your therapist disapprove of you entering this activity? If yes, please describe why: ____ ____	□ Yes □ No
3.	Do you have any history of emotional or psychological problems? If yes, please describe: ____ ____ Please list any medications you are taking for psychological problems: ____ ____	□ Yes □ No
4.	Are there any reasons why you should not fast or live alone? If yes, please describe: ____ ____	□ Yes □ No
5.	Do you wear a Medic-Alert Tag or any other marker of a medical problem? If yes, please describe: ____ ____	□ Yes □ No
6.	Were you hospitalized in the last five years? If yes, please describe: ____ ____	□ Yes □ No
7.	Do you have allergic or anaphylactic reactions to any insults, such as environmental substances, foods, drugs, insect bites or stings? If yes, please describe (including medications you carry for exposures): ____	□ Yes □ No

8.	Have you ever experienced a seizure of any kind? If yes, please describe: ____ ____	□ Yes □ No
9.	Do you have heart disease of any kind? If yes, please describe: ____ ____	□ Yes □ No
10.	Do you have a lung disease or any kind of breathing problem? If yes, please describe: ____ ____	□ Yes □ No
11.	Do you have hemophilia or any other disorder that impairs blood-clotting? If yes, please describe: ____ ____	□ Yes □ No
12.	Do you have any muscle, joint, or bone related disabilities? If yes, please describe: ____ ____	□ Yes □ No
13.	Do you have trouble with headaches? If yes, please describe: ____ ____	□ Yes □ No
14.	Do you have any kidney disease? If yes, please describe: ____ ____	□ Yes □ No
15.	Do you have hypoglycemia or diabetes? If yes, please describe: ____ ____	□ Yes □ No
17.	Do you have any other chronic disease that, in any way, threatens your health? If yes, please describe: ____	□ Yes □ No
18.	If you walked on the level for a mile at an average pace would you get out of breath, have pains in the chest, develop muscle fatigue or have pains in your legs? Describe your degree of fitness in your own words:____ ____	□ Yes □ No
19.	Are you taking <u>any</u> medication at present time? If yes, specify drugs, the doses, & reason for each: ____ ____ ____	□ Yes □ No
20.	Any dietary preferences or needs? If yes, please describe: ____	□ Yes □ No
21.	Have you been infected with COVID? If yes, when? ____________ If yes, any persistent symptoms? Please describe: ____ Have you completed a full course of a COVID vaccine? If yes, the date: _______________ __________	□ Yes □ No □ Yes □ No □ Yes □ No
22.	Have you had a tetanus shot in the last 10 years? If yes, the date: ____________	□ Yes □ No

This information is accurate & complete. I agree to cooperate with the retreat facilitators to design a wilderness practice with full consideration of my health history and health concerns. I give my permission to the School of Lost Borders guides on this trip to seek emergency medical diagnosis or treatment for me in the event that I am unconscious or unable to make my own decisions. Our role in offering medical treatment will be limited to emergency first-aid and either transportation to the nearest medical facility, or contacting such a facility to arrange emergency transport.

SIGNATURE; ____

(If under 18 years old, must be parent or guardian's signature)