Ph: 1-604-836-2321 *Fax: 1-604-909-4948* *Email: info@naturaltrekking.com*

Participant Booking Information

A. Personal Information

Full Legal Name: _____

Address: _____

City: _____ Prov / State: _____ PC / ZIP: _____

E-Mail Address: _____

Phone: Home: _____ Business _____

Cell _____ Fax _____

B. Tour Details

Tour Date: _____

Duration of Tour: _____

Payment Method: _____

C. Hiking and Related Activities

Please list your pertinent hikes (if any), training and related activities. _____

D. Training and Conditioning _____

E. Meals / Snacks:

Are there any foods you cannot eat or do not like? _____

F. Emergency Contact Information:

Primary Contact Name: _____ Relationship? _____

Day phone(s) _____ Night Phone _____

Alternate Contact Name: _____ Relationship? _____

Day phone(s) _____ Night Phone _____

Please Note: Medical/Accident Insurance is Strongly Recommended

G. Natural Trekking Marketing Questionnaire:

How did you hear about Natural Trekking Friends? Internet? Previous _____

AGREEMENT

The information I have provided on the Participant Information is true and correct.

Participant's Signature: _____ **Date** _____

If under 18, Parent must also sign: _____ **Date** _____

Parent please print full name: _____

Ph: 1-604-836-2321 *Fax: 1-604-909-4948* *Email: info@naturaltrekking.com*

Participant Medical Information

Hiking can be strenuous. In addition, medical care may not be immediately available in the backcountry. We do not want you to engage in any activity that would be detrimental to your health or which would be opposed by your doctor because of recent illness, injury, surgery, etc. If you have any questions regarding your participation in this activity, please contact your doctor.

Participant Name: _____ Date of Birth: _____

Gender: _____ Height: _____

_____ Weight _____

How would you describe your health (use additional page if necessary? _____

_____

Please answer the following questions by checking off Yes or No. If **Yes** to any, please describe on a separate sheet.

Have you ever had any of the following?

Allergies	Yes	_____	No	_____
List allergies:				
Asthma	Yes	_____	No	_____
Epilepsy	Yes	_____	No	_____
Heart Disease	Yes	_____	No	_____
Speech, vision, or hearing impairment	Yes	_____	No	_____
High Blood Pressure	Yes	_____	No	_____
Dislocations	Yes	_____	No	_____
Frostbite	Yes	_____	No	_____
Do you get cold easily?	Yes	_____	No	_____
Shoulder, Back, or Knee problems	Yes	_____	No	_____
Diabetes	Yes	_____	No	_____
Are you pregnant?	Yes	_____	No	_____

Are you taking any medications (for what? dosage?)

Do you have any limitations on your activities?

Do you have any other conditions that might affect your health?

Please Note: Medical/Accident Insurance is Strongly Recommended

AGREEMENT

The information I have provided on the Participant Medical Information is true, complete and correct.

Participant's Signature: _____Date_____

If under 18, Parent must also sign: Signature: _____ Date_____

Parent please print full name: _____