



Medical History Form

It is advised by WTA's physician advisor that volunteers be in good physical condition to participate in WTA work parties. Thoroughly completing the participation questionnaire will support WTA in creating a safe and inclusive environment for our events, including assessing individual readiness based on medical history. These work parties may require physically and mentally demanding exertion, including extended hiking or backpacking, for multiple days in a row. These work parties may be in remote locations without easy access to medical facilities or means of contacting rescue and medical personnel.

WTA is requesting this information in the interest of the safety of both you and other crew members. The answers you provide will help your crew leader and WTA staff be better prepared to respond in an emergency. WTA may contact you to discuss your capacity to successfully complete the work parties for which you have registered. This form is valid for work parties during this calendar year. Information on this form is confidential and only reviewed by WTA staff. Thank you for your participation and information during this process.

Emergency Contact Information

First and Last name

City, State

Email Address

Phone Number

If they can't be reached contact:

First and Last Name

City, State

Email Address

Phone Number

Allergies

Are you allergic to bee stings? If so, how severe is your reaction?

Do you carry an anaphylaxis kit? _____ Yes _____ No

Do you have any food allergies or dietary restrictions? Please contact us if you have questions about our ability to accommodate your needs.

Do you have any other allergies? Please describe, noting type and severity.

Medical History

Describe any injuries, operations or hospitalizations you've experienced in the past year.

Describe any illness or pre-existing conditions. For example: hepatitis, lyme disease, heart or lung conditions.

Do you have any heat illness concerns or circulation issues due to cold weather?

Are you taking any medications? List type, dosage, frequency of use, side effects and purpose.

Please state below any other health conditions, limitations or restrictions of which you are aware. Some examples include: asthmatic, orthopedic, diabetic or cardiac concerns, limited vision or hearing