



**WILDERNESS  
COMMITTEE**

**NATIONAL OFFICE**  
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**WildernessCommittee.org**

V A N C O U V E R • V I C T O R I A • W I N N I P E G • T O R O N T O

# HEALTH DECLARATION

Dear Volunteer,

The health declaration is vital to sign up to be a volunteer on a Wilderness Committee expedition. Without this health declaration the Wilderness Committee will not permit you to participate in an expedition.

Health declaration checklist:

- Please answer the questions in the participant portion of this section accurately, including as much detail as possible so that we can determine you are registered for a suitable project and accommodate you to the best of our ability
- **Return your declaration form to our office prior to your expedition start date**

Accurate completion of this health declaration will be helpful if you have a medical emergency while on the project. Participants who do not disclose medical conditions that limit their ability to safely participate on a project risk removal from the project at their own expense. You must alert Wilderness Committee of any changes to your medical status or medications that occur after submission of this Health Declaration.

## Expedition I would like to join:

Expedition Name \_\_\_\_\_ Start Date (mm-dd-yy) \_\_\_\_\_

## Personal information:

First Name \_\_\_\_\_ Family Name \_\_\_\_\_ Date of birth (mm-dd-yy) \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ ☐ lb -or- ☐ kg

Have you ever had any of the following conditions? Please check all that apply and provide as much additional detail as possible for any condition you have (use the space provided on the next page if necessary). Your form will not be considered complete without this requested information.

- |                                                                                                                                             |                                                                                 |                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Active Hepatitis, Type: _____                                                                                      | <input type="checkbox"/> Epilepsy/seizures                                      | <input type="checkbox"/> Joint conditions (arthritis, bursitis, etc) |
| <input type="checkbox"/> Allergies                                                                                                          | <input type="checkbox"/> Head injury                                            | <input type="checkbox"/> Kidney or liver conditions                  |
| <input type="checkbox"/> Anemia                                                                                                             | <input type="checkbox"/> Headaches/migraines                                    | <input type="checkbox"/> Musculoskeletal condition                   |
| <input type="checkbox"/> Cancer                                                                                                             | <input type="checkbox"/> Heart conditions (incl. disease, murmur, irregularity) | (osteoporosis, fibromyalgia, etc)                                    |
| <input type="checkbox"/> Chronic lung conditions                                                                                            | <input type="checkbox"/> Heat and/or cold sensitivity                           | <input type="checkbox"/> Orthopedic problems (sprains or fractures)  |
| <input type="checkbox"/> Chronic back conditions                                                                                            | <input type="checkbox"/> Heatstroke                                             | <input type="checkbox"/> Skin conditions                             |
| <input type="checkbox"/> Dizziness/balance conditions                                                                                       | <input type="checkbox"/> High blood pressure                                    | <input type="checkbox"/> Stomach/intestinal conditions               |
| <input type="checkbox"/> Eating disorder                                                                                                    | <input type="checkbox"/> Immune system conditions                               | <input type="checkbox"/> Tuberculosis/exposure to TB                 |
| <input type="checkbox"/> Endocrine/thyroid conditions                                                                                       | <input type="checkbox"/> Immune system conditions                               | <input type="checkbox"/> Tetanus, Year of last shot: _____           |
| <input type="checkbox"/> Asthma - Cause: _____ Can you self-medicate? <input type="checkbox"/> Yes <input type="checkbox"/> No              |                                                                                 |                                                                      |
| <input type="checkbox"/> Diabetes/Hypoglycemia, Type: _____ Can you self-medicate? <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                 |                                                                      |

Have you been hospitalized or had surgery in the past two years? If yes, please include provide as much detail as possible ☐ Yes ☐ No  
in the space below:

Do you have any phobias which might inhibit your participation? If yes, please describe in the space provided below: ☐ Yes ☐ No  
(E.g. Acrophobia – fear of heights, aquaphobia – fear of water, agrizoophobia – fear of wild animals)

Do you have any allergies? Include drugs, food, insect stings etc. If yes, list the type of reaction, the severity, and required treatment. Please indicate any medications you will be carrying to treat your allergy:

☐ Yes ☐ No

Do you have any conditions that are not already indicated on above?

☐ Yes ☐ No

Do you have any dietary restrictions? If yes, please include provide as much detail as possible in the space below:

☐ Yes ☐ No

Are you susceptible to infections or immune -compromised? If yes, please include provide as much detail as possible in the space below:

☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

If you have any of the conditions listed on previous page, please provide as much detail as possible here, including dates of treatment/surgery, and potential effects on your participation on this project:

**We may need to contact you to discuss your condition to assess how it may affect your ability to safely and effectively participate on your chosen project.**

**Mental Health**

Have you ever been diagnosed with or been treated for a psychiatric condition such as bipolar disorder or depression? If yes, please provide details:

☐ Yes ☐ No

Have you ever been hospitalized or in residential treatment for psychiatric care? If yes, please provide the dates of hospitalization/treatment:

☐ Yes ☐ No

May we contact your psychologist/psychiatrist? If yes, please provide name and number below:

☐ Yes ☐ No

**Medications**

Do you take any prescription or non-prescription medications for the previously-mentioned conditions? If yes, please list the medication, reason for taking it, length of time you have been taking it, and the current dosage:

☐ Yes ☐ No

Medication:	Reason for taking:	Date started taking:	Dosage:

Please add any additional information:

Note: If you bring prescription medication, please bring twice as much as you think you need, packed in waterproof containers, and with written instructions for use.

## Vision and Hearing

Do you have difficulty seeing in low-light conditions or have unusual difficulties seeing at night?

☐ Yes☐ No

Do you have color blindness?

☐ Yes☐ No

Do you have glaucoma, macular degeneration, cataracts or other visual impairment? If yes, please provide details:

☐ Yes☐ No

Are you hearing impaired? If yes, describe how this could affect your participation:

☐ Yes☐ No

Is there anything else that could affect your ability to participate in Wilderness Committee field activities? If yes, please provide details:

☐ Yes☐ No

## Current Level of Physical Activity

Please complete frequency and time/distance and then check the box that applies to you.

Activity Type	Frequency	Time/distance	Relaxed	Moderate	Intense
Walking			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swimming			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Stamina	Easily	Moderately well	With difficulty	Not at all
Before tiring I can walk 1 mile/1.6km	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Before tiring I can walk 5 miles/8 km	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can hike 3 hours over rough terrain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can hike 3 hours with a 40 lb/18 kg pack over rough terrain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you use any walking aids? If yes, please elaborate on the type of aid (e.g. cane, crutches, walker, wheelchair)

☐ Yes☐ No

and reason for need:

## Swimming Ability

☐ Non-swimmer☐ Recreational swimmer☐ Strong swimmer☐ Current water life-saving

Comments: (optional)

## Participant Affirmation

I understand the physical demands of the project for which I have signed up. I understand it is my responsibility to determine if I am able to participate safely given any medical conditions I may have. I have reviewed this Health Declaration and the Briefing document with a doctor. I have answered all questions on this Health Declaration truthfully and completely, and understand that truthful disclosure of medical conditions will not necessarily lead to being excluded from a project.

I authorize the Wilderness Committee Field Team to consent to medical treatment, the administration of x-ray examination, anesthetics, blood transfusion, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician or surgeon or the most qualified medical provider. I authorize any such medical provider to release information about me and my condition and treatment to Wilderness Committee. I agree to pay for any and all costs associated with such treatment, including the costs of evacuation, if any, that are not covered by insurance.

I understand that Wilderness Committee will disclose information on this Health Declaration to the lead field staff of the project to which I am travelling and will hold this information on file for a period of at least seven years following my return from the project.

Wilderness Committee

☐ may☐ may not

contact my doctor.

Participant signature: Date (mm-dd-yy):

Note the Wilderness Committee reserves the right to bar you from participation based on the information provided.

**Form Checklist:**

- Have you provided as much information as possible on any health conditions you have indicated?
- Have you signed and dated the Health Declaration above?

Doctor's name: \_\_\_\_\_

Doctor's address: \_\_\_\_\_

Telephone/fax: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency contact: (name and phone number of two people) \_\_\_\_\_

\_\_\_\_\_

Next of kin: (name and phone number of two people if different from above) \_\_\_\_\_

\_\_\_\_\_

**Submit at:**

**wildernesscommittee.org/field/register**

