

RIVER OF GRASS CANOE EXPEDITION
January 2-7, 2010
HEALTH SUGGESTIONS AND MEDICAL QUESTIONNAIRE

All participants in the River of Grass Canoe Expedition are required to complete and return the enclosed Medical Questionnaire by **October 15, 2009**. The information you provide will help your trip leader(s) with the information he/she or they may need in the event you need medical assistance.

MEDICATIONS

Participants taking prescription medication(s) should pack **DOUBLE** their normal requirements due to possible loss or damage. It is suggested that each complement of your dosages be packed separately in a waterproof container. If you regularly take any non-prescription medication(s) these should be listed in the medical questionnaire.

FOOD ALLERGIES

You may be cooking your meals utilizing freeze dried or camping style foods. These foods should be consistent with your allergic needs. If you have any food allergies these should be listed in the questionnaire and you should indicate the type of reaction to such food.

NUTRITION

The River of Grass Expedition will comply with Leave No Trace camping ethics. What we pack in we will pack out, except what we consume for fuel. You will be advised in advance what sanitary facilities will be available and where they will be located. We suggest that you begin preparation for your paddle by cutting out junk food and moderating your intake of caffeine, alcohol and tobacco. This will contribute to your fitness. Even though the trip will be in flat water a clear head and quick reflexes will contribute to your safety.

INSURANCE

During the Expedition you should carry with you the medical insurance card provided by your carrier. You or your insurance carrier will be responsible for the cost of your medical care. Neither the River of Grass Expedition nor any of the sponsoring organizations assume liability for those expenses.

SIGNATURE AND RETURN OF FORMS REQUIRED

You must sign, date and return the Medical Questionnaire to The Arthur R. Marshall Foundation in the envelope provided by the date in the first paragraph of this letter.

QUESTIONS

If you have a question regarding this letter or the enclosed Medical Questionnaire contact Marshall Foundation at plantcypress@aol.com

GENERAL INFORMATION

Applicant's Name: _____ . Gender: _____
Date of Birth: _____ 19 ____ . Height: _____ . Weight: _____
Address: _____ , City _____ , State _____
Zip Code: _____ email: _____
Home Phone: _____ Cell Phone: _____
Area Code/Number Area Code/Number

EMERGENCY CONTACT

Person's Name: _____ Relationship: _____
Home Address: _____ City: _____ State: _____
Home Phone: _____ Work Phone: _____
Area Code/Number Area Code/Number
Cell Phone: _____ email: _____
Area Code/Number

SECONDARY EMERGENCY CONTACT

Person's Name: _____ Relationship: _____
Home Address: _____ City: _____ State: _____
Home Phone: _____ Work Phone: _____
Area Code/Number Area Code/Number
Cell Phone: _____ email: _____
Area Code/Number

PRIMARY CARE PHYSICIAN

Name: _____ Phone : _____
Area Code/Number
Office Address: _____ City _____ State: _____

CONSENT TO EMERGENCY MEDICAL TREATMENT AND PAYMENT

SIGNATURE AND DATE REQUIRED

The undersigned participant in the River of Grass Canoe Expedition hereby consents to any emergency medical treatment, including but not limited to anesthesia, operation, hospitalization, including transportation (whether for emergency or not) which might be necessary for the treatment of any condition, illness, or injury which may occur during or as a result of my participation. I agree to be responsible for all costs incurred for such care and/or treatment.

APPLICANT'S SIGNATURE: _____ DATE: _____

MEDICAL HISTORY: PAST AND PRESENT

Have you in the past suffered from any injury, disease or condition which might be described as serious or disabling or life-threatening?

YES ___ NO ___ If "YES" please give details, including date(s):

CONDITIONS AND SYMPTOMS (Please check "Yes" or "No" to all)

If you answered "YES" to any of the above items, please explain in the space below. Add additional sheets as needed.

INCLUDE THE FOLLOWING INFORMATION:

- * What specific symptoms occur
- * Treatment Recommended
- * How often symptoms occur
- * How long symptom lasts
- * Date of last occurrence
- * How you are affected

PERSONAL / LIFESTYLE

If you are paddling solo or with a person with whom you are well acquainted you need not answer those questions preceded by an asterisk. Please remember that this questionnaire will be important to the trip leader and will contribute to a safe and enjoyable trip for you and your companions. Please be assured that we have no desire to be any more intrusive than we believe is absolutely necessary.

Do you possess a valid driver's license? _____. State of Issue and license number _____.

Lifestyle: The answers to this section will be held in the strictest of confidence and we not be used or disseminated to anyone other than the trip leader. In the event the trip leader determines further contact with you is necessary in order to evaluate your answers to this section he will contact you.

Do you use alcohol? _____.

Do you use tobacco? _____.

Do you use drugs other than alcohol or prescription on a regular basis? _____.

Have you have a current problem with substance abuse? _____.

Have you ever been convicted of a felony? _____.

If you answer to any of the foregoing questions is "YES", please provide a detailed summary of the facts and circumstances below:

HOW MANY DAYS, BEGINNING JANUARY 2, 2010 AND ENDING JANUARY 7, 2010, ARE YOU READY, ABLE AND WILLING TO DEVOTE TO ACCOMPLISH THE EXPEDITION? (Check the appropriate dates)

ALL. _____ LESS THAN ALL, BUT THE FOLLOWING DATES:

___ SATURDAY, JANUARY 2.

___ SUNDAY, JANUARY 3

___ MONDAY, JANUARY 4

___ TUESDAY, JANUARY 5

___ WEDNESDAY, JANUARY 6

___ THURSDAY, JANUARY 7

On or before October 15, 2009:

Email completed forms to plantypress@aol.com or return completed forms to:

Arthur R. Marshall Foundation

2806 S. Dixie Hwy.

West Palm Beach, Florida 33405