

Participant Information Form (PIF)



Trip Date

Name (as it appears on your passport)

Address

City State Zip

Birthdate Age Weight (for plane considerations)

Passport Number Expiration Date

Citizenship

In an Emergency notify Relation

Emergency Contact Day & Night phone

Medical – Health History

Do you have or have you had any of the following medical conditions?

Cardiac Problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Bleeding Disorders	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Chest Pains	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Shortness of breath	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Chronic Illness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Pregnant NOW	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Learning Disability	<input type="checkbox"/> YES	<input type="checkbox"/> NO
High Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Allergy to stings/bites	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Food Allergies	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Seizures	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Mobility Impairment	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Back Trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Sensory Impairment	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Blackout Spells	<input type="checkbox"/> YES	<input type="checkbox"/> NO			

Please provide additional information for any “YES” responses above

Do you have any pertinent medical conditions that may affect you or others on the trip (other than listed above)?

How would you describe your general health?

List specific allergies and reactions (pollen, insect bites, foods, medications, clothing, etc)

Are you currently taking any prescription medications? If so, please list

List non-prescription medications taken regularly

Do you carry an epinephrine kit? YES NO

If YES, where?

Any previous First Aid or lifesaving experience? YES NO

Dietary Information for Meal Preparation

Please return this form as soon as possible, so we can make accommodations for your dietary needs.
Thank you!

Do you have any dietary restrictions, allergies or other considerations?

Do you drink coffee? YES NO Regular or Decaf

Do you drink tea? YES NO Caffeinated or Herbal?

Vegetarians/ Vegans - Please indicate the proteins/ items you **DO NOT** eat

- Red Meat Chicken Fish Shellfish Bacon Dairy Onion Cilantro
 Chile Gluten

** If you smoke, we ask you to please do so away from group activities. There is no smoking allowed in Pure Baja Travels tents. We will provide you with a container for disposal of cigarette ends. Thank you!*

**** Consult your physician with any questions or concerns you have regarding your personal fitness and physical/mental ability to participate in this adventure. You will be in a remote area with limited access to medical care.**

Are you requesting a single supplement for your stay? YES NO

How did you find out about Pure Baja Travels?

Please complete and return this form upon receipt to:

Pure Baja Travels LLC
P.O. Box 4787
East Lansing, MI 48826

or email it to:

info@purebajatravels.com

If you have any questions, please feel free to contact us.

Thank you and we will see you soon!