



TRIP REGISTRATION

PERSONAL INFORMATION

NAME: _____	DATE OF BIRTH: _____	HEIGHT: _____
STREET ADDRESS: _____	SEX: _____	WEIGHT: _____
CITY, STATE, ZIP: _____	EMAIL: _____	
HOME PHONE: _____	HOW DID YOU	
WORK PHONE: _____	HEAR OF ELAKAH? _____	

TRIP INFORMATION

PLEASE REGISTER ME FOR THE FOLLOWING TRIP(S):		
TRIP NAME: _____	TRIP DATES: _____	THRU _____
TRIP FEE: \$ _____	50% DEPOSIT: \$ _____	BALANCE: \$ _____
CHECK ___ VISA ___ MC ___ CC#: _____		EXPIRES: _____

EMERGENCY CONTACTS

RELATIVE/FRIEND: _____	DR. NAME: _____
STREET ADDRESS: _____	DR. PHONE: _____
CITY, STATE, ZIP: _____	INSURANCE CO.: _____
HOME PHONE: _____	POLICY NO.: _____
WORK PHONE: _____	INS. PHONE: _____

FUNCTIONAL ABILITIES

PLEASE INDICATE WHETHER YOU HAVE DIFFICULTY FUNCTIONING FULLY IN ANY OF THE FOLLOWING AREAS:	
BOYANCY: Y__ . N__ .	VISION: Y__ . N__ .
CIRCULATION: Y__ . N__ .	HEARING: Y__ . N__ .
MOBILITY: Y__ . N__ .	SENSATION: Y__ . N__ .
DECISION MAKING: Y__ . N__ .	STAMINA: Y__ . N__ .
REASONING: Y__ . N__ .	SPEECH: Y__ . N__ .
MOTOR CONTROL: Y__ . N__ .	BALANCE: Y__ . N__ .
JUDGEMENT: Y__ . N__ .	
FOR ANY "Y" ANSWERS, PLEASE EXPLAIN YOUR SITUATION: _____	

DO YOU HAVE ANY ALLERGIES OR DIETARY RESTRICTIONS? Y__ . N__ . PLEASE SPECIFY: _____

DO YOU TAKE ANY PRESCRIPTION MEDICATIONS? Y__ . N__ .
IF YES, PLEASE SPECIFY NAME OF MEDICATION AND ITS TREATMENT: _____

DO YOU USE ANY ASSISTIVE DEVICES? Y__ . N__ . PLEASE SPECIFY: _____