

TRAILBLAZERS INTERNATIONAL  
**Applicant Medical Information (B)**



**Please read this before completing the Medical Information form:**

This Medical Questionnaire must be filled out in full and submitted to the Program Supervisor before your application is processed. Please be sure to mark all boxes legibly with a blue or black ball-point pen. **The final page must be filled out by a medical doctor.**

All information submitted will be treated in the strictest confidence. Certain questions on this form relating to the applicants family are routine questions a hospital would ask of a patient and relate not only to physical health but psychological health as well.

Name of Applicant: \_\_\_\_\_

Applicants Medical Insurance Policy information:

Policy Number \_\_\_\_\_

Name of Policy \_\_\_\_\_

Policy Expiry Date \_\_\_\_\_

***\*The applicant must present the medical insurance policy to the program supervisor upon arrival in Canada.***

Applicants Passport Information:

Passport Number \_\_\_\_\_ Country of Issue \_\_\_\_\_ Expiry Date \_\_\_\_\_

Name of applicant as it appears on the passport \_\_\_\_\_

Gender: \_\_\_\_\_

Height: \_\_\_\_\_

Hair Colour: \_\_\_\_\_

Eye Colour: \_\_\_\_\_

Physical marks (scars, etc.): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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Applicant Address:

Street

City

Country

Postal Code

Home telephone number:

Name of mother:

Name of Father:

Emergency Contact name:

Relationship of Emergency Contact:

Emergency Contact Number:

2nd Emergency Contact name:

Relationship of 2nd Emergency Contact:

2nd Emergency Contact Number:

Has the applicant ever been hospitalized?     Yes     No

If yes, for what reason:

Has the applicant ever been treated for head, neck or spinal trauma or injury?

Yes     No

If yes, please give details, including the date, nature and treatment of the injury:

Does the applicant suffer from any allergies?     Yes     No

If yes, please specify:

Is the applicant allergic to penicillin?     Yes     No

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**MEDICAL CERTIFICATION**

**\*This certification is to be filled out by a registered medical doctor:**

Note to Doctor:

This applicant has applied to participate in the Trailblazers Adventure and Leadership Program. This program involves physical activities and exertion such as swimming, hiking, camping (wood cutting), and sports. The hiking/backpacking component of the trip will require the applicant to carry a 12 – 13 Kg backpack for extended periods of time and up to elevations as high as 2,000 Meters. A normal, healthy youth and adult is normally able to complete these tasks.

Name of applicant: \_\_\_\_\_

Name of Physician: \_\_\_\_\_

Physicians Address (place of practice): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is the applicant:

Physically fit

Moderately fit

not fit

Fit, with the following exception(s):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the applicant require any medications while participating in this program? If so, please specify the medication, dosage and purpose for the medication:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's signature: \_\_\_\_\_

Date signed: \_\_\_\_\_