



Kayak Class Registration / Health History Information Sheet (CONFIDENTIAL)

The following information is requested to maximize fun, learning and safe participation on and off the water and to respond to emergency situations. We strive to accommodate a wide range of abilities. Information is Confidential.* Please contact us if you have questions.

Name: _____ Preferred Pronoun(s): _____

Address: _____

City / State / Zip: _____ Email: _____

Phone # : _____ Alternate Phone: _____

Height: _____ Weight: _____ Date of Birth: _____ Age: _____

Emergency Contact Information: Relationship: _____

Name: _____ Email: _____

Address: _____

City / State / Zip: _____

Phone # : _____ Alternate Phone: _____

Course Registering For / Dates (if private instruction, please share objectives):

Swimming ability (with or without life jacket):

Paddling / kayaking experience:

This course follows ACA (American Canoe Association) Course Guidelines
ACA courses are open to all individuals who acknowledge the ability to perform
Essential Eligibility Criteria (EEC) and course prerequisites, included in course outline.

Essential Eligibility Criteria / Course Prerequisites:

I have reviewed EEC and course prerequisites and meet both



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I have reviewed EEC and course prerequisites and have further questions
 I have not received EEC and course prerequisites

Mark the best answer:

Can you seal your airway passages while under water? Yes No I don't know
 Do you use any type of external head /neck support? Yes No I don't know
 Are you able to wear a properly fit life jacket (PFD)? Yes No I don't know

Health History: Your assistance is requested to optimize group and personal safety / success throughout the course. The following questions are optional and will remain confidential.

Pertinent Health Information: *please check YES if an area of concern*

<i>Condition</i>	<i>Yes</i>	<i>No</i>	<i>Condition</i>	<i>Yes</i>	<i>No</i>	<i>Condition</i>	<i>Yes</i>	<i>No</i>
Fitness			Mobility			Heat sensitivity		
Endurance			Balance			Cold sensitivity		
Injury(s)			Communication			Seizures		
Asthma			Hearing			Other:		
Allergy(s)			Vision			Other:		
Heart Condition			Sensory Loss			Other:		

Additional Information (use additional page(s) if needed):

Current medications / side effects:

Request for accommodation(s):

I attest the information on this form is correct, to the best of my knowledge.

Name (print): _____ Signature & date: _____

If registrant is a minor provide guardian information below:

Name (print): _____ Signature & date: _____



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***Please note:** This information is confidential. Email is not secure.

Please MAIL this form to:

Bay Cliff Health Camp PO Box 310 Big Bay, MI 49808