

## PARTICIPANT DETAILS FORM

Group Name	<input type="text"/>
Participant Name (as it appears on passport)	(First) <input type="text"/> (Last) <input type="text"/>
Passport Number	<input type="text"/>
Place of Passport Issue	<input type="text"/> Expiration <input type="text"/>
Birthdate	<input type="text"/> (dd/mm/yyyy)
Citizenship/Nationality	<input type="text"/>
Gender	(M) <input type="checkbox"/> (F) <input type="checkbox"/>
Mailing Address	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Post Code	<input type="text"/>
Phone (day)	<input type="text"/>
Phone (evening)	<input type="text"/>
Phone (mobile)	<input type="text"/>
E-Mail	<input type="text"/>

### Emergency Contact Information

Contact Person	<input type="text"/>
Address	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>

Post Code	<input type="text"/>
Their Telephone Home	<input type="text"/>
Their Telephone Work	<input type="text"/>
Their Mobile Telephone	<input type="text"/>
Their Relationship with Participant	<input type="text"/>

**Dietary/Medical Information**

<p>Dietary Requirements</p>	<p>Please indicate foods you do NOT eat:</p> <p><input type="checkbox"/> Red Meat    <input type="checkbox"/> Fish</p> <p><input type="checkbox"/> Chicken    <input type="checkbox"/> Dairy</p> <p>Other: <input type="text"/></p>
<p><b>Health/Medical Conditions</b> Please alert us to anything and everything, including:</p> <ul style="list-style-type: none"> <li>- prescription medications currently being taken;</li> <li>- history of medical conditions and/or illnesses;</li> <li>- family medical history</li> <li>- date of last tetanus booster</li> </ul>	<input type="text"/>
<p><b>Allergies</b> Please specify drug or food allergies</p>	<input type="text"/>
<p>Describe your outdoor background and regular physical activity</p>	<input type="text"/>