



# WILD EARTH JOURNEYS

## MEDICAL FORM

**“Pilgrimage To Mongolia, Acupuncturists Without Borders”  
World Healing Exchange Program with Photographer Thomas  
Kelly and National Geographic Expert Carroll Dunham  
July 27<sup>nd</sup>- Aug 14<sup>th</sup>, 2010**

To be prepared for medical emergencies during our time together, we require all participants to supply the following information. Although we treat this information as confidential, we will encourage you to share information about pre-existing conditions and any personal concerns with others in your group, so they can help you in the best way possible in any emergency.

NAME: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Please circle any of the following which apply, giving details in the space provided, or on the back of this sheet:

Current medications: (since: \_\_\_\_\_/\_\_\_\_\_)

Allergies (including insect bites/stings):

Hypoglycemia: (since: \_\_\_\_\_/\_\_\_\_\_)

Susceptibility to headaches:

Hospitalized in the last year?

If yes, why?

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Appendicitis: (date: \_\_\_\_\_/\_\_\_\_\_)

Diabetes:

Epilepsy:

Heart problems/Blood pressure:

Kidney disease:

Back, knee or other joint injuries?

If yes, when?

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Counseling history:

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Other concerns:

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Your degree of fitness (in your own words):

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Dietary preferences: (e.g. Vegetarian/vegans)

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Personal medications & remedies that you will be bringing:

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Health Insurance: \_\_\_\_\_

Group #: \_\_\_\_\_

Last medical visit (date and doctor):  
(\_\_\_\_\_/\_\_\_\_\_) \_\_\_\_\_

Last medical check-up (date and doctor)  
(\_\_\_\_\_/\_\_\_\_\_) \_\_\_\_\_

Last tetanus shot (date): (\_\_\_\_\_)

Your doctor: \_\_\_\_\_

Medical Group: \_\_\_\_\_

Hometown/Phone: \_\_\_\_\_

Contact in case of emergency: \_\_\_\_\_

Relationship: \_\_\_\_\_

Hometown/Phone: \_\_\_\_\_

Does this person know you are participating in this journey?  
YES / NO

This information is accurate and complete. I agree to cooperate with Wild Earth Journeys to design my wilderness practice and pilgrimage with full consideration of my health history and health concerns.

Signed: \_\_\_\_\_

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

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Name (print): \_\_\_\_\_