COSTA RICA TRAIL
www.latranstica.org

Medical file:

Name: First Name:

Bith Date: Sex: F ☐ M ☐

Heigh: Weight : Blood group:

Medical history: Did you get any medical problem which required elaborate examination, long treatment or hospitalisation?

Surgical history: Have you ever been operated and/or anaesthetised ? If yes, when and why, on which occasions? ?

Allergic past records:

Current treatment: Are you on any kind of medication ? If so please specify the treatment?

Do you wear ?

- Glasses : ☐ Yes ☐ No
- Contact Lenses : ☐ Yes ☐ No
- Prosthesis : ☐ Yes ☐ No

Do you follow a special diet: ☐ Yes ☐ No

If so which kind of diet:

Are you in conformity with vaccinations ?

- DT Polio : ☐ Yes Date :
  ☐ No
- Hepatitis : ☐ Yes Date :
  ☐ No
- Covid 19 : ☐ Yes Date :
  ☐ No

Do you have first aid knowledge ?

☐ Yes Which Grade :
☐ No

COMMENTS :

IN CASE OF ACCIDENT:

Repatriation contract, medical evacuation N°:

Name of your insurance company:
Tel N°:
Name of your doctor :
Tel N°: :
Contact name in case of emergency :
Tel N°: :

Certified real and true

Date : Signature :