

Diabetes(list the type of medication)? Yes/No

Asthma(how often)? Yes/No

Epilepsy(list the type of medication)? Yes/No

Mental or emotional Instability(list the type of medication)? Yes/No

Pregnancy(at which stage)? Yes/No

Irritable bowel syndrome? Yes/No

Any other digestive problems,please list? Yes/No

Joint injury(specify)? Yes/No

Are you on any Medications(please list them)? Yes/No

Do you wear glasses or contact lenses? Yes/No Glasses/Lenses

Date of last tetanus inoculation or booster:

Any Additional Details:

IN CASE OF EMERGENCY PLEASE CONTACT

Name:

Phone number:

Address:

Relationship:

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