HEALTH & DIETARY REVIEW

Knight Inlet Lodge requires that each Lodge guest completes our Health & Dietary Information questionnaire. This information is important, it will assist our Lodge staff in applying our risk management plan and to prepare contingency plans in the event of a health or medical emergency. Please answer all the questions and sign your name in the appropriate place. If more room is required to record information, please do so on an additional piece of paper and attach to this form.

Please Print Clearly

Name:		**File #**	

1. **Do you have travel medical insurance?** ☐ Yes ☐ No

2. **Have you received a COVID-19 vaccination?** ☐ Yes ☐ No ☐ Prefer Not To Answer

2a. **Have you had any COVID-19 related symptoms in the last 7 days?** ☐ Yes ☐ No

3. **Medical Conditions:** Do you have any of the following medical conditions?

Heart Condition	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Chronic Headaches	☐ Yes	☐ No	Nose bleeds	☐ Yes	☐ No
Seizure Disorders	☐ Yes	☐ No	Depression	☐ Yes	☐ No

If you answered **Yes** to any of the above conditions, please provide details;

Do you have any chronic physical limitations, (bad back, joint problems, etc.)?	☐ Yes	☐ No
Have you been under a Doctor's care in the past 12 months?	☐ Yes	☐ No
Have you undergone any surgery within the last year?	☐ Yes	☐ No

If you answered **Yes** to any of the above conditions, please provide details;

4. **Medications**

Please ensure that you have packed with you any medication(s) that you will require for the duration of your stay at the Lodge.

Are you currently taking any prescription or non-prescription medications? ☐ Yes ☐ No

If you answered **Yes**, please provide the following information;

Name of the medication(s): _____

What is the daily dosage: _____

What are the side effects to you of this medication?

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Are there any effects to you if you miss your medication? ☐ Yes ☐ No

If **Yes**, describe the effects;

What are the effects if you take too much of your medication?

5. Allergies

Do you have any known allergies, or have you ever had a severe allergic reaction? ☐ Yes ☐ No

If your answer was **Yes**, was the reaction localized or systemic? ☐ Localized ☐ Systemic

Please describe what causes the reaction, what happens to you, and how you manage a reaction;

6. Dietary Information

Do you follow a Vegetarian diet? ☐ Yes ☐ No

Do you follow a Vegan diet? ☐ Yes ☐ No

Are you Lactose Intolerant? ☐ Yes ☐ No

Are you Gluten Sensitive? ☐ Yes ☐ No

Additional Notes

Please indicate which of the following that you are ***ALLERGIC*** to:

☐ Fish ☐ Shellfish ☐ Beef ☐ Pork ☐ Lamb Other: _____

7. Can you swim?

☐ Yes ☐ No

8. Are you pregnant

☐ Yes ☐ No

If **Yes**, what trimester are you currently in? ☐ First ☐ Second ☐ Third

9. In Case of Emergency Contact Person

Name: _____ Relationship: _____

Tel (Day): _____ Tel (Evening): _____ Cell: _____

I, have completed this Health & Dietary Information questionnaire accurately, truthfully, and to the best of my knowledge. I understand that withholding information could possibly compromise the care provided to me in the event of a medical emergency.

SIGNATURE	DATE