



Registration Form

NOTE : Fill in this form, save it and email it as an attachment to info@nunavikparks.ca. A Park employee will contact you to complete your registration.

Part A - Personal Information

Which park are you registering for: **Parc national**

To register for Parc national Kuururjuaq, complete Appendix 1 Additional Information, which will be transmitted to you by a park employee.

Last Name

First Name

Address

City/Town

Province/State

Postal/Zip Code

Country

Telephone

Date of Birth (dd-mm-year)

Gender M F

Email

1 Is your trip being handled by a travel agency? Yes No If yes, specify

2 Are you a professional guide in charge of a group? Yes No

To determine if you meet the criteria set by Nunavik Parks. Contact us

Note: If your trip is being handled by a travel agency or a professional guide, complete **Part A, D and E** of this form.

Emergency Contact Information

A Last Name

First Name

Country

Gender M F

Relationship

Telephone

Day

Evening

Cell

Email

B Last Name

First Name

Country

Gender M F

Relationship

Telephone

Day

Evening

Cell

Email



Part B - Level of Preparedness

1 Do you have travel wildrness experience in remote areas? Yes No

2 If so, how would you rate your level of wilderness travel experience in remote areas?

Beginner Intermediate Expert

Describe your last five outdoor excursions related to the activities you plan to do in the park.

1.	<input type="text"/>	Dates	<input type="text"/>
2.	<input type="text"/>	Dates	<input type="text"/>
3.	<input type="text"/>	Dates	<input type="text"/>
4.	<input type="text"/>	Dates	<input type="text"/>
5.	<input type="text"/>	Dates	<input type="text"/>

3 What level of first aid training do you have?

None

Standard First Aid and CPR *

Advanced Wilderness and Remote First Aid

Wilderness and Remote First Aid * Other

* Attach a copy of your certifications.

Specify any additional medical, search and rescue, emergency, or outdoors training in wilderness remote areas that you have.

4 Are you a health care worker? Doctor Nurse Other:

5 Would you be willing to assist in a rescue if asked? Yes No



For Administrative Use Only

Registration no. Last Name First Name

Travel group or agency, or professional guide

No. of persons

Time in the park

Arrival date (dd-mm-yyyy)

Departure date (dd-mm-yyyy)

Means of travel

Employee responsible for the registration

Arrival

Departure

NOTES

MEDICAL FORM

MEDICAL ASSESSMENT AND PHYSICAL FITNESS QUESTIONNAIRE
FOR INTENSIVE OUTDOOR ACTIVITIES IN A REMOTE REGION



HEALTH INSURANCE NO. _____ BLOOD TYPE _____ WEIGHT _____

Please provide HONEST responses to the following questions.

Yes	No	
		1- Has a health care professional ever informed you that you have or could have a heart problem?
		2- Do you experience pains in your chest or heart either when involved in an activity or at rest?
		3- Do you experience dizziness or weakness when at rest, involved in an activity, or due to cold or heat?
		4- Has a health care professional ever informed you that your blood pressure is too high?
		5- Do you suffer from joint or bone problems that could worsen due to intensive physical activity or rugged climate conditions (cold, humidity)? Specify:
		6- Do you suffer from allergies (pollen, cold, animals, nuts, dairy, etc.)? Specify:
		7- Do you take regular medication? Specify:
		8- Do you experience difficulty adapting to heat or cold?
		9- Do you have any phobias (of heights, water, insects, darkness, constricted spaces, etc.)? Specify:
		10- Do you wear glasses or contact lenses?
		11- Do you have any eye or visual problems, such as judging distances or heights, sensitivity to intense light or other problems that are not correctable with glasses or contact lenses? Specify:
		12- Do you have any serious hearing problems that make communicating with others, either near or far, difficult? Specify:
		13- Do you have any dermatological problems (skin) that are affected or worsened by exposure to the sun, heat, cold, etc.? Specify:
		14- Do you suffer from numbness at work, at rest or during any other activity?
		15- Do you suffer from hemophilia or do you take blood-thinning medication? Specify:
		16- Do you get cramps or feel heat or pain in your calves when walking on a slope or on stairs?
		17- Do you suffer, or have you ever suffered, from respiratory problems (asthma, laboured breathing during activity or due to cold, humidity or heat, secretions from your lungs when involved in an activity, etc.)? Specify:
		18- Are there any other physical or mental considerations that might prevent you from travelling with a group far from urban centres and under the conditions described by the person responsible for the activity? Specify:

MEDICAL INSURANCE - Insurer

Insurance company: _____ Telephone: _____

Policy number: _____

Valid from _____ to _____

Does your insurance policy cover remote regions emergency evacuation? YES NO

If you answered no to the preceding question, complete the following section: _____

REMOTE REGIONS EMERGENCY EVACUATION

Insurance company: _____ Telephone: _____

Policy number: _____

Valid from _____ to _____

Name (block letters): _____

Date: _____