



Environmental Traveling Companions

**Trip Reservation Form: Baja Espiritu Santo Island**

7 days, 6 nights with 4 nights camping and 2 nights hotel in La Paz, Baja, Mexico, December 5-11, 2026

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Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

How did you hear about this trip?

What does this trip mean to you?

Please list the total number of people in your group. *(Please have each person complete their own reservation form)*

Describe your previous experience with Sea Kayaking, camping, and wilderness trips.

Would you like to apply for financial assistance to make this trip happen either for yourself or your attendant?

Please list any questions comments or concerns you may have.

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**CONFIDENTIAL HEALTH & EMERGENCY INFORMATION** (*Please answer all questions thoroughly*)

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Weight \_\_\_\_\_

Waist Size \_\_\_\_\_ Chest Size \_\_\_\_\_ Height \_\_\_\_\_

*Please note that, due to the nature for the Personal Floatation Devices (PFDs) used on this trip, we reserve the right to not accommodate anyone with a chest size larger than 52" or anyone weighing more than 250lbs.*

Please rate the following:

I exercise (1 = never; 5 = every day)

My upper body strength is (1 = poor; 5 = excellent)

I can independently walk or ambulate 1/2 mile over rough terrain (1 = unable; 5 = easily)

I can lift 25 lbs. And carry it 100 yards. (1 = unable; 5 = easily)

My general physical condition is (1 = poor; 5 = excellent)

Do you have sensory, physical, cognitive or emotional disabilities?

If yes, please provide additional information

Are you currently under the regular care of any medical specialists?

If yes, for what conditions?

Are you currently taking any prescriptive medications?

If yes, please list them and describe what they are for.

Do you use any assistive devices?

If yes, please list them.

Do you use an attendant in your daily life?

If yes, please explain for what needs.

Do you have any food allergies or dietary restrictions?

If yes, please list them.

Have you had a tetanus shot in the last 10 years (this is required for participation in the trip)? Yes      No

Have you experience any of the following:

<input type="checkbox"/> Incontinence	<input type="checkbox"/> Chemical dependency	<input type="checkbox"/> Ear perforation	<input type="checkbox"/> Hepatitis A or B
<input checked="" type="checkbox"/> Lung Disease	<input type="checkbox"/> Allergies	<input type="checkbox"/> Communicable diseases	<input type="checkbox"/> Head Injury
<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Seizures	<input type="checkbox"/> Asthma or other Resp.	<input type="checkbox"/> Dysreflexia	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Stroke	<input type="checkbox"/> Back Conditions	<input type="checkbox"/> Decubitus ulcers	
<input type="checkbox"/> Urinary/bladder infections	<input type="checkbox"/> Balance problems	<input type="checkbox"/> Knee problems	

If you answered yes to any of the above, please describe more fully here:

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**EMERGENCY INFORMATION** (*Please answer all questions thoroughly*)

Your health insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

Physician \_\_\_\_\_ Phone: \_\_\_\_\_

Relative or close friend \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (Day) \_\_\_\_\_ Phone (Evening) \_\_\_\_\_

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**Please read carefully and sign below.**

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

**This form must be signed.** If you are under 18, or if you are considered a vulnerable adult, your legal guardian must sign it. You cannot participate on a trip unless we have a signed registration form.

Please submit this form via email or post:

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