# CONFIDENTIAL MEDICAL FORM

Your place on an Extreme Outdoor Adventures expedition is confirmed when we receive all forms, filled out and signed. This medical form is a way to ensure a safe experience for you, appropriate to your level of physical fitness. If we have any questions about your capability to complete the program, we will call and discuss it with you. All information will be held confidential.

Expedition Name _____

Expedition Dates _____

1. Name_____

Age_____D.O.B_____Height_____cm. Weight_____kg ____Male ____Female

Address. _____

_____

Home phone_____Business_____

Phone/Mobile _____

2. Person to be notified in case of illness or injury (nok )Name_____Relationship_____

Address.__ _____

_____

Home phone_____Business Phone _____ Mobile _____ Email _____

3. Family Doctor (name)_____Phone_____

Address.__ _____

_____

**EACH PARTICIPANT IS RESPONSIBLE FOR ANY MEDICAL EXPENSES AND MUST BE COVERED BY HIS/HER OWN EVACUATION, SICKNESS AND ACCIDENT INSURANCE.**

Do you have evacuation and medical insurance coverage? Yes_____No_____

Name of Insurance Company _____ Policy Number_____

Address _____ Emergency Phone_____

If NO, do you need assistance in purchasing an appropriate policy? _____

**MEDICAL HISTORY**

We urge you to be completely thorough in providing us with the information requested. Failure to disclose such information could result in serious harm to the applicant and his/her fellow participants. If you arrive at the program start with a pre-existing condition or injury that is not indicated on your medical form, you may not be allowed to participate.

**IF YOU CHECK YES TO ANY QUESTION BELOW, DESCRIBE PROBLEMS IN DETAIL ON THE RIGHT SIDE OF PAGE OR ON A SEPARATE SHEET.**

1. Give a brief statement of your general health

_____

| | | Check One | Comments |
|---|---|---|---|
| 2. | Do you have any present medical problems? (Describe) | Yes___No___ | _____ |
| 3. | Are you taking any medication? (List all medications and dosages) | Yes___No___ | _____ |
| 4 | Blood Type | | _____ |
| 5. | Do you have a current tetanus immunization? (Must be within last 10 years) | Yes___No___ | _____ |
| 6. | Have you had any surgeries? (Give dates) | Yes___No___ | _____ |
| 7. | Are you allergic to any of the following? (Please list all allergies and severity of reaction) | Yes___No___ | _____ |
| | | | _____ |
| | Medication | Yes___No___ | _____ |
| | Food | Yes___No___ | _____ |
| | Insect Bites | Yes___No___ | _____ |
| | Other. | Yes___No___ | |
| 8. | Do you smoke? If so, how many cigarettes per day? | Yes___No___ | _____ |
| 9. | Have you had or do you have a substance abuse problem (alcohol, drugs)? | Yes___No___ | _____ |
| 10. | Do you suffer unusually from the cold ie, Reynaud's Syndrome, chilblains, previous frostbite, sleep coldly etc. | Yes___No___ | _____ |

11. Do you have problems with vision or hearing? Yes___No___ _____
12. Do you suffer motion sickness? Yes___No___ _____
13. Do you have high blood pressure? (Describe) Yes___No___ _____
14. Do you have heart murmurs, episodes of irregular heartbeat, shortness of breath or chest pain on exertion? (If so describe symptoms) Yes___No___ _____
15. Do you have asthma? If YES has the condition been stable for the past year? _____
16. Do you have any other respiratory or cardio-vascular problems? Yes___No___ _____
17. Have you had or do you have ulcers, heartburn, or other intestinal problem? Yes___No___ _____
18. Do you require a special diet? Use separate sheet if required. Yes___No___ _____
19. Do you have any eating disorders, anorexia, bulimia, hypoglycemia? Yes___No___ _____
20. Have you had hepatitis or jaundice? (If so, give date) Yes___No___ _____
21. Do you have chronic bladder infections, difficulty with urination, bed-wetting or other bladder or kidney problems? (Describe) Yes___No___ _____
22. Do you have seizure: (describe severity and frequency) If not listed above, list medications and dosages taken for seizures. Use separate sheet if required. _____ Yes___No___
23. Do you suffer from severe headaches, dizziness or fainting? (Describe) _____
24. Do you have claustrophobia, agoraphobia, acrophobia? (strong fear of confined places, open areas, heights) Yes___No___ _____ Yes___No___ _____
25. Do you have problems with your neck, back, arms, ankles or knees that limit your activities? (Describe) _____ Yes___No___
26. Do you have bleeding problems? _____
27. Do you have diabetes, thyroid trouble or other endocrine problems? Yes___No___ _____
28. Do you have chronic skin problems (rashes, sun sensitivity, etc.)? Yes___No___ _____
29. Have you had frostbite or a reaction to cold temperatures? (Describe) Yes___No___ _____
30. Have you suffered from muscle cramps, heat exhaustion or had other reactions to warm temperatures? Yes___No___ _____ Yes___No___
31. For females: Do you have premenstrual or menstrual problems? _____
Are you pregnant? Yes___No___ _____
32. Does your health prevent you from participating in any physical activities? Yes___No___ _____
33. Have you ever been under treatment of a psychologist or psychiatrist? Yes___No___ _____
If "YES" are you currently under treatment? Yes___No___ _____
Under treatment within the last two years? Yes___No___ _____

Reason for treatment: Family Issues____ Divorce_____ Career_____Depression____
Substance Abuse____ Suicide attempt_____Other

34. Please describe in detail what you do routinely to maintain fitness (mention activities and frequency):

_____

_____

35. What is your swimming ability?
Non-swimmer_____Can swim at least 100 yards_____Strong swimmer_____Hold current lifesaving certificate____

36. Any other details.

_____

_____

**Consent is hereby given for any emergency anaesthesia, operation, hospitalisation or other treatment that might become necessary. The information provided above is a complete and accurate statement of the physical and psychological factors which may affect my participation on an E.O.A. expedition. I realize that failure to disclose such information could result in serious harm to fellow participants and myself and agree to indemnify and hold E.O.A Expeditions harmless if all relevant information is not disclosed.**

Date Applicant's signature _____

Signature of Parent or Guardian (if under 18) _____