ATTACHMENT C: MEDICAL INFORMATION FORM

Adventure name: [ ]

Requested Dates: From: MM DD YYYY To: MM DD YYYY

First Name and Surname exactly as is on Passport: First Name Surname

Please have this form completed and signed by your primary medical practitioner. Please complete all pages of the form. Please attach to this form, any and all additional medical information that is pertinent to your adventure or is vital to your medical care and safety.

The information you provide is essential for your health and safety on the adventure. It will remain confidential however WA reserves the right to share this information with any and all staff, support staff, medical providers, and third-party suppliers and their support staff if the dissemination of such information is essential for your safety, health or in the course of providing you or others with medical treatment. You agree to hold WA, its staff, support staff, medical providers and third-party suppliers and their support staff harmless from such dissemination, and release all parties as described in this paragraph from any and all liability for the release of such information as contained herein. If you withhold any information pertaining to medical conditions that you have or have had, you are putting yourself and all other members of the adventure at risk, and such action may cause you to be liable for withholding such information.

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Date of Birth: MM DD YYYY Gender: Male [ ] Female [ ]

Weight: [ ] Height: [ ] Blood Type: [ ]

Do you have /have you ever suffered from any of the following? (check yes/no for each)

Condition	Yes	No	Condition	Yes	No
Asthma:	[ ]	[ ]	Stroke:	[ ]	[ ]
Epilepsy:	[ ]	[ ]	Migraines:	[ ]	[ ]
Diabetes:	[ ]	[ ]	Stomach Ulcers or Gastritis:	[ ]	[ ]
High Blood Pressure:	[ ]	[ ]	Hemorrhoids:	[ ]	[ ]
Angina:	[ ]	[ ]	Blood Clotting Disorders:	[ ]	[ ]
Ischaemic Heart Disease or Heart Attack:	[ ]	[ ]	Mental Illness, including anxiety and depression:	[ ]	[ ]
Blood Circulation issues such as Raynaud's Disease:	[ ]	[ ]	Cancer:	[ ]	[ ]
			HIV:	[ ]	[ ]
Congenital Heart Defect or Disease:	[ ]	[ ]	Hepatitis, B or C, or any other infectious disease:	[ ]	[ ]

If you answered yes to any of the conditions above, please give details: date of diagnosis, type of treatment received and whether it is ongoing or not.

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Applicant shall be advised that WA will provide meals as outlined in WA's travel documents and / or literature specific to the Applicant's adventure. WA will work with the Applicant in order to provide for special dietary requirements, however such efforts shall merely be reasonable and WA is under no contractual requirement to provide such meals, supplements and / or any other nourishment in order to meet the Applicant's dietary requirements beyond that which is outlined in WA's travel documents and / or literature specific to the Applicant's adventure, such supplies subject to reasonable substitution if required. Applicant is aware that they are responsible and shall incur any and all additional costs for the purchase, supply, transportation and preparation of any and all dietary supplies and requirements that are outside the scope of those outlined in WA's literature and / or travel documents specific to the Applicant's adventure.
I confirm that the information provided herein is correct and that I have not withheld any information pertaining to my medical history. The signatories to this form have provided complete, true and accurate information and have done so with free will and no undue duress. As such, the Client and the Medical Practitioner affirmatively agree and state that the client is medically cleared to embark on the adventure.

Client Signature: ______ Date: MM DD YYYY

Medical Practitioner Signature: ______ Date: MM DD YYYY

CONTACT DETAILS OF MEDICAL PRACTITIONER

Name: First Name Surname

Address: Street Apt. or Suite

City State Zip

Home Phone: ______ Mobile: ______

Fax: ______ Email: ______

Medical License Information: ______

NEXT OF KIN OF PERSON TO BE NOTIFIED IN CASE OF EMERGENCY

Surname and First Name exactly as is on Passport:

First Name Surname

Relation to Client: Relation

Address: Street Apt. or Suite

City State Zip

Home Phone: ______ Mobile: ______

Fax: ______ Email: ______

PLEASE RETURN BY E-MAIL, FAX OR POST TO OUR ADMINSTRATION OFFICE USING THE INFORMATION BELOW:

ATTACHMENT C: MEDICAL INFORMATION FORM (CONTINUED)

Have you ever had any operations? (including minor surgery, cosmetic surgery, and laser treatment of myopia). If so, please give details and dates below.

Have you ever been in a major accident? If so, please give the details of the type of accident (traffic, climbing, skiing, etc.) and the injuries you sustained?

Have you ever spent more than one night in a hospital as a patient? If so, please give the details, the dates and reason for admission.

Do you take any medications regularly? Please give the details of the name (or generic name) the dose and frequency below.

Do you have any allergies? (including food allergies, latex allergies, environmental allergies and drug allergies)?

Do you have any significant family history of illness or disease? (illness affecting your blood relatives).

Have you ever suffered from Acute Mountain Sickness, High Altitude Cerebral Edema, High Altitude Pulmonary Oedema, frostbite or any other medical problems while at high altitude? Please give condition, dates, altitude which the symptoms developed, treatment received and any ongoing problems related to that event or any recurrence of the same symptoms.

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Please list any and all dietary requirements or constraints that you might have.

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