



MEDICAL FORM

Full name:

Date of birth:

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

1. Name:

Relationship:

Phone no: Day:

Evening:

Mobile:

2. Name:

Relationship:

Phone no: Day:

Evening:

Mobile:

Travel insurance details:

General physical condition:

Please indicate any known allergies (food/drug/insect/etc.):

Allergies life threatening:

Allergies non life threatening:

Date of last Tetanus inoculation or booster:

Are you on any medications* (prescription or non-prescription)?

Yes/No

If yes, please specify:

* Please bring duplicate set of medication to be carried and stored separately.

Have you been under a doctor's care in the past 12 months?

Yes/No

If yes, please specify:

Do you have any physical limitations?

Epilepsy, diabetes, susceptibility to colds, headaches, nosebleeds, fainting, asthma, hay fever, emphysema, or other any other medical conditions:

Do you have a history of joint injury (tendonitis, bursitis, sprain, dislocation, or other)?

If yes, please specify:

Eyesight: Excellent ___ Good ___ Fair ___ Poor ___

Do you wear either Glasses* and/or Contact lenses?

Yes/No

*If you are dependent upon glasses for adequate vision, a spare set should be brought with you.

Do you feel that you have any psychological limitations? (i.e. fear of water, fear of heights, etc.)

Please explain:

The above medical information is complete and accurate. If any of the information changes, I will inform the tour leader(s) so that the changes can be recorded. I have read the trip outline and physical requirements. I am in good physical condition to participate. I have read the disclosure information and understand the possible hazards that may be encountered on the trip. I agree to adhere to the rules and regulations set up by the leaders of the trip to minimize risk and ensure safety.

Signature of Applicant _____ Date _____
