MEDICAL INFORMATION

EVERY MEMBER OF AN EXPEDITION MUST COMPLETE SECTION A AND B OF THIS FORM. SECTION C IS TO BE COMPLETED IF YOU CHECK AT LEAST ONE OF THE CATEGORIES LISTED IN SECTION A. THE COMPLETED FORM MUST BE SUBMITTED NO LATER THAN 90 DAYS PRIOR TO DEPARTURE.

PLEASE NOTE: OUR EXPEDITIONS ARE CONDUCTED IN ENGLISH, THEREFORE ALL FORMS AND DOCUMENTS ARE PROVIDED IN ENGLISH, AND MUST BE COMPLETED IN ENGLISH.

SECTION A: PERSONAL INFORMATION

(Every member of the expedition must complete this section)

Your name as it appears on your passport _____

Medical Insurance

Medical insurance that includes emergency medical evacuation coverage is mandatory. Please check the box that follows:

☐ I understand that medical insurance with medical evacuation coverage is mandatory.

Insurance Policy Details

Name of the insurance company _____ Policy number _____

Insurer's emergency telephone number _____

Personal Emergency Information

Person to contact in case of an emergency _____
FIRST LAST

Relationship _____ Phone _____ E-mail _____

Dietary Restrictions

Please list any dietary restrictions _____

_____

Date of your last full medical check-up _____

Section A continued

Check all medical conditions for which you are currently under the care of a physician, or for which you have been under care in the past 6 months:

- ⬭ Neurological – stroke, motor neuron diseases, multiple sclerosis, Parkinson's disease, polio, disorders of balance, seizures (epilepsy), dementia, memory disorders, intellectual impairment
- ⬭ Musculoskeletal – joint replacements, muscle disorder (e.g. muscular dystrophy)
- ⬭ Eyes – glaucoma
- ⬭ Ambulation – use of a cane, walker
- ⬭ Sensory – blindness, deafness, disorders of sensation (e.g. peripheral neuropathy)
- ⬭ Physical – amputee, post trauma physical disabilities, post surgery physical disabilities
- ⬭ Gastrointestinal – Crohn's disease, inflammatory bowel disease, ulcer
- ⬭ Heart – bypass surgery, angioplasty, stent, high blood pressure, rhythm problems, pacemaker, heart failure
- ⬭ Immune disorders – HIV, AIDS, steroid use
- ⬭ Cancer – any type
- ⬭ Lung – emphysema (COPD), asthma, ever been on a ventilator
- ⬭ Mental Health disorders – depression, bipolar disease, mania, schizophrenia, psychosis
- ⬭ Endocrine – diabetes, thyroid
- ⬭ Blood thinner – anticoagulants (coumadin)
- ⬭ Medications – any prescribed medications (exclude vitamins, supplements and laxatives)
- ⬭ Pregnant at time of travel

NEXT:

IF YOU CHECKED AT LEAST ONE OF THE CATEGORIES IN SECTION A ABOVE, PLEASE COMPLETE SECTION C OF THIS DOCUMENT.

IF YOU CHECKED NOTHING IN SECTION A ABOVE, PLEASE COMPLETE SECTION B BELOW AND SIGN WHERE INDICATED.

SECTION B

I attest that I am in good health and mobility, and capable of performing normal activities on this expedition. I am able to climb steep stairs. I further attest that I am capable of caring for myself during the expedition, and that I will not impede the progress of the expedition or the enjoyment of others aboard. I understand that this expedition will take me far from the nearest medical facility and that all expedition members must be self-sufficient. I am further aware that an emergency evacuation may be unavailable, expensive and delayed. I understand that the medical facilities and attention available aboard the ship are limited to basic first aid care.

Signature of traveler _____ Date _____

SECTION C

IF YOU CHECKED AT LEAST ONE OF THE MEDICAL CONDITIONS LISTED IN SECTION A, THEN IN SECTION C YOU MUST COMPLETE THE FIRST PART AND YOUR PHYSICIAN MUST COMPLETE THE SECOND PART. EACH OF YOU MUST SIGN IN THE DESIGNATED SPACES AT THE END OF SECTION C.

Part 1

Your name _____
LAST FIRST MIDDLE

Name of ship _____

Part 2

Name of physician _____

Phone number _____ Fax number _____

E-mail _____

Office address _____

City _____ State _____

Zip code _____ Country _____

Please list any current medical conditions, infirmities or disabilities. If the patient is over 50 or has any heart disease, if possible, please give them a copy of their EKG.

_____

_____

_____

_____

List all medicines currently taken by this patient. If more space is needed attach a separate sheet.

TRADE NAME	GENERIC NAME	DOSE / STRENGTH	FREQUENCY	PURPOSE

List any sensitivities or allergies to drugs or food:

If this patient has been hospitalized, or had surgery, at any time during the last five years, please tell us when and why:

What physical limitations does this patient have?

Please describe any walking aids used by this patient:

How many weeks pregnant will this patient be at the time of travel?

Physician's signature _____ Date _____

Patient's signature _____ Date _____

12242 Business Park Drive, Suite 21 Truckee, CA USA tel +1 (530) 582-1246 fax +1 (530) 582-1279 or email to karyn@ice**axe**expeditions.com