

WHITNEY & SMITH

Legendary Expeditions Inc. MEDICAL AND PERSONAL FORM

Please complete this form to the best of your ability as it is in the best interest of yourself, your fellow trip members, and your guides that all of the information provided is accurate and complete. Completion of this form is mandatory for trip participation and it must be returned to us at the time of registration for your trip. Your answers are for our records and preparations only and will be considered confidential.

Note to participants travelling outside Canada and the U.S.:

Please check with your local health unit for current inoculation requirements and other health recommendations.

Participants Name: _____ Date: _____ Date of Birth: _____.

In case of emergency contact: _____ Phone: _____.

Sex: ___ Height: ___ Weight ___ Evaluate your health: Fair: ___ Good: ___ Excellent: ___.

Evaluate your physical condition: Below average: ___ Average: ___ Above average: ___ Excellent: ___.

Evaluate your swimming ability: Non-swimmer: ___ Poor: ___ Fair: ___ Good: ___ Excellent: ___.

Name and phone number of your physician: _____.

Date of your last tetanus inoculation: _____ (Note: A tetanus injection is valid for ten years. It is mandatory for all participants to ensure up-to-date tetanus protection prior to trip departure.)

Are you now under the care of a physician? YES NO

If so, what is the condition being treated? _____.

Has there been any change in your general health the past year? YES NO

If so, please explain: _____.

Have you ever had any serious illness, injury or operation? YES NO

Have you been hospitalised or had a serious illness within the past five years? YES NO

If so, what was the problem? _____.

Do you have or have you had any of the following diseases or problems:

Allergies; if so, to what, and how do you react? _____ YES NO

Arthritis YES NO

Asthma YES NO

Cardiovascular disease: heart trouble, heart attack YES NO

Coronary insufficiency, coronary occlusion, arteriosclerosis, stroke YES NO

Fainting spells or seizures YES NO

Hepatitis, jaundice or liver disease YES NO

Hay fever YES NO

High blood pressure	YES	NO
Hives or skin rash	YES	NO
Inflammatory rheumatism (painful swollen joints)	YES	NO
Kidney trouble	YES	NO
Low blood pressure	YES	NO
Tendinitis, Tenosinovitis, Carpal-tunnel syndrome, wrist injuries	YES	NO
Do you have any blood disorders? If so, please explain:_____.	YES	NO
Women: are you pregnant?	YES	NO

Are you taking any of the following (please print the drug name):

Antibiotics or Sulfa drugs	YES	NO
Anticoagulants (blood thinners)	YES	NO
Antihistamines	YES	NO
Anti-inflammatories	YES	NO
Cortisone (steroids)	YES	NO
Digitalis or drugs for heart condition	YES	NO
Insulin	YES	NO
Nitroglycerin	YES	NO
Pain killers	YES	NO
Other (please list drug names):_____.	YES	NO

Are you allergic to or have you reacted adversely to:

Anti-inflammatories	YES	NO
Aspirin	YES	NO
Barbiturates, sedatives or sleeping pills	YES	NO
Codeine or other narcotics	YES	NO
Iodine	YES	NO
Local anaesthetics	YES	NO
Penicillin or other antibiotics	YES	NO
Sulfa drugs	YES	NO
Other drugs or foods (please specify):_____.	YES	NO

Do you wear contact lenses? YES NO

Have you had any serious trouble associated with any previous medical treatment? YES NO

List any special dietary requirements:_____.

Do you have any disease, condition, or problem not listed above that you think we should know about?
If so, please explain:_____.

Declaration: I affirm that I am medically, physically and in all other respects, fit and fully able to participate in adventure travel and that I have no special medical requirements or conditions except as outlined above.

Signature of participant:_____ Date:_____.