WHOA TRAVEL

MEDICAL INFO FORM & RELEASE

The information you provide here is essential for your health and safety on your adventure.*
Please complete all the pages and have it signed by your Primary Medical Practitioner.

ADVENTURE NAME _____ START DATE _____

ADVENTURER FULL NAME _____

DOB _____ WEIGHT _____ HEIGHT _____ SEX F M

Do you have/have you ever suffered from any of the following?

Please circle Y or N, for Yes or No, respectively.

Y	N	ASTHMA	Y	N	STOMACH ULCERS OR GASTRITIS
Y	N	STROKE	Y	N	HIGH BLOOD PRESSURE
Y	N	EPILEPSY	Y	N	BLOOD CLOTTING DISORDERS
Y	N	MIGRAINES	Y	N	ISCHAEMIC HEART DISEASE OR HEART ATTACK
Y	N	DIABETES	Y	N	MENTAL ILLNESS, INCL. ANXIETY/DEPRESSION
Y	N	CANCER	Y	N	BLOOD CIRCULATION ISSUES LIKE RAYNAUD'S DISEASE
Y	N	HEMORRHOIDS	Y	N	CONGENITAL HEART DEFECT OR DISEASE
Y	N	ANGINA	Y	N	HEPATITIS B OR C
Y	N	HIV	Y	N	ANY OTHER INFECTIOUS DISEASE

If you answered yes to any of the conditions above, please give details.

Including date of diagnosis, type of treatment received, and whether it is ongoing or not.

_____

_____

Have you ever had any operations? If so, please give details and dates below.

Including minor surgery, cosmetic surgery, and laser treatment of myopia.

_____

_____

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, but not limited to food, latex, environmental, and drug allergies.

Do you have any significant family history of illness or disease?

Have you ever suffered from Acute Mountain Sickness, High Altitude Cerebral Edema, High Altitude Pulmonary Edema, frostbite or any other medical problems while at high altitude? If yes, 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

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 Adventurer and the Medical Practitioner affirmatively agree and state that the Adventurer is medically cleared to embark on this Adventure.

Adventurer Signature and Date

Medical Practitioner Signature and Date

MEDICAL PRACTITIONER NAME

ADDRESS

PHONE (____)_____ EMAIL _____ MEDICAL LICENSE INFO _____

***** All information will remain confidential, however WHOA reserves the right to share this information with any and all staff, medical providers, third-party suppliers, and 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. By signing this, you agree to hold WHOA, its staff, medical providers, third-party suppliers, and 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. 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.