

SOUTHERN SEA VENTURES MEDICAL HISTORY FORM

Please list on this medical form all health issues and medical history. Most medical problems do not preclude participation on our trips. However, environmental factors and remote destinations with no medical facilities or means of rapid evacuation may create a risk that is best to avoid. Our staff are well trained in wilderness first aid and carry an extensive first aid kit. Most trips do not have an accompanying doctor.

Please complete this form accurately and completely to assist our trip leaders in the event of a problem. The medical form will go with the leader on the trip and then be destroyed.

If you are age 65 or older we require a medical certificate from your doctor approving your participation in this activity. Your doctor can call our office for more information on the level of activity for your trip.

Please return the completed medical form to us promptly!

NAME _____ BIRTHDATE _____ HEIGHT _____ WEIGHT _____
TRIP _____ DEPARTURE DATE _____

SPECIAL DIETARY REQUIREMENTS: _____

IN CASE OF EMERGENCY PLEASE CONTACT

Name _____ Home Phone _____ Work Phone _____

Address _____ Relationship _____

Doctors Name _____ Doctors Phone _____

PLEASE LIST ALL INFORMATION REGARDING THE FOLLOWING

Physical Condition _____ Any Known Allergies (list) _____

Do you suffer from Anaphylaxis? (severe allergic reaction) _____

Do you have any physical limitations? _____

DATE OF LAST TETANUS INNOCULATION OR BOOSTER(must be current within the last ten years) _____

Are you on any Medications? _____ If yes please provide details. _____

Have you been under a doctors care in the last 12 months? _____ If yes provide details. _____

Do you wear glasses or contact lenses? _____

ANY HISTORY OF THE FOLLOWING (if so please add details)

1. Raised blood pressure? Yes/No _____

2. Heart or circulatory disease? Yes/No _____

3. Asthma? Yes/No If yes, how often are the attacks? _____

4. Epilepsy? Yes/No List medication if any and last attack? _____

5. Diabetes? Yes/No If on medication, list type. _____

6. Pregnancy? Yes/No If yes, at which stage? _____

If pregnant have you been tested for gestational diabetes? _____

7. Ulcers? Yes/No _____

8. Digestive or bowel disorders? Yes/No _____

9. Joint Injury? Yes/No Specify date of injury and joint. _____

10. Surgical Operations? Yes/No If yes, specify. _____

11. Mental/Emotional Instability? Yes/No List medication if any _____

Any Additional Details: _____

Signature of applicant _____ Date _____

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