Please return by email, fax or post
to our Administration Office:
20 Clos Chantey Mourry
74400 Argentière
France

Tel: + 33 4 50477192
Fax : + 33 9 72319592
Email: info@himalayanexperience.com

MEDICAL FORM

Surname:	First Name:	
Expedition / Trek:		
Dates From:	To:	
Date of birth	Gender:	
Weight:	Height:	
Resting pulse:	Respitory rate:	Blood Pressure:

Please ensure that this form is completed and signed by your usual medical practitioner.
Please complete all pages of the form.

The information you provide is essential for your health and safety on the expedition. It will remain confidential and only be seen by the expedition leader and the expedition doctor unless it becomes essential to share it with guides higher up on the mountain. The decision to disclose medical information will be taken by the expedition leader if the need should arise. The information you give **will not** prevent you from taking part in the expedition. 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 expedition at risk, furthermore failure to disclose a medical condition can invalidate expedition insurance and prevent or delay evacuation and repatriation.

Do you have any medical concerns that you would like to raise with the medical team (in confidence) prior to the trip? Yes □ No □ If 'Yes', then we will put you in direct contact with the expedition doctor.
' ave you ever had lung/respiratory problems (e.g. asthma, COPD, pneumonia, TB, pulmonary embolism (PE), lung surgery)? Yes □ No □ If 'Yes', please provide details here:
Have you ever had heart/cardiac/blood vessel problems (e.g. high blood pressure, angina, heart attack, deep vein thrombosis (DVT), heart surgery)? Yes □ No □ If 'Yes', please provide details here:
Have you ever had abdominal/bowel problems (e.g. hernias, stomach ulcers, reflux, inflammatory bowel disease, abdominal surgery, constipation, diarrhoea)? Yes □ No □ If 'Yes', please provide details here:
Have you ever had brain/nerve problems (e.g. epilepsy, seizure, severe headaches, migraines, sciatica, carpel tunnel syndrome, reduced sensation, brain surgery)? Yes □ No □ If 'Yes', please provide details here:
Have you ever had kidney/urinary/liver problems (e.g. recurrent cystitis, renal failure, liver failure, jaundice, hepatitis, pyelonephritis)? Yes □ No □ If 'Yes', please provide details here:
Have you ever had hormone/endocrine problems (e.g. diabetes, thyroid problems)? Yes □ No □ If 'Yes', please provide details here:
Have you ever had bone/joint/tendon problems (e.g. back problems, ankle problems, knee problems, serious injuries, orthopaedic surgery)? Yes □ No □ If 'Yes', please provide details here:

Have you ever had psychiatric/psychological problems (e.g. depression, schizophrenia, bipolar disorder, psychosis, overdose, self-harm)?
Yes □ No □
If 'Yes', please provide details here:

Have you ever had altitude problems (e.g. acute mountain sickness (AMS), high altitude cerebral oedema (HACE), high altitude pulmonary oedema (HAPE))?
Yes □ No □
If 'Yes', please provide details here:

Have you ever had cold related problems (e.g. frostbite, Raynaud's syndrome/very cold hands and feet, cold-induced asthma, chilblains, immersion/trench foot, hypothermia)?
Yes □ No □
If 'Yes', please provide details here:

Have you ever had heat related problems (e.g. heat exhaustion, heat stroke, sun stroke)?
Yes □ No □
If 'Yes', please provide details here:

Are you currently seeking specialist advice or treatment for any medical conditions?
Yes □ No □
If 'Yes', please provide details:

Have you ever suffered from a serious medical condition that you have not mentioned above (e.g. one requiring admission to hospital, long-term treatment or surgery)?
Yes □ No □
If 'Yes', please provide details:

Have you had a dental check-up in the last year?
Yes □ No □
This is recommended:

Do you have any ongoing dental problems?
Yes □ No □
If 'Yes', please provide details:

What is your blood group (if known)?
Group ________________

Have you ever had a blood transfusion?
Yes □ No □
If 'Yes', please provide details:

Do you have any form of physical or mental impairment or disability not mentioned above?
Yes □ No □
If 'Yes', please provide details:

What is the highest altitude over 3,000m (10,000ft) that you have been to?
Altitude ________________
How many times have you been over 3,000m (10,000ft)?
Number ________________

Are you currently taking any medications regularly (including oral contraceptive, over-the-counter medications, inhalers, creams and herbal remedies)?
Yes □ No □
If 'Yes', please list the medication's name, dose and how often it is taken:

Please note that you MUST bring enough of the above medications with you on the expedition so that there is a spare set with you in case some are lost / damaged. We will happily store these in the medical kit for you if you so wish.

Have you ever had an allergic reaction to any medication?
Yes □ No □
If 'Yes', please list the medication's name and describe the symptoms/treatment of the reaction:

Have you ever had an allergic reaction to foods or environmental triggers (e.g. cats)?
Yes □ No □
If 'Yes', please provide details here:

Declaration

- I agree that the above information is true and accurate to the best of my knowledge.
- As far as I am aware I am medically fit to partake in a remote expedition which will be both physically and mentally demanding and include exposure to extremes of heat, cold and altitude.
- I understand that I am responsible for providing all my normal medications and supplies for the treatment of my **pre-existing medical conditions** for the duration of the expedition.
- I understand that my medical information shall be kept confidential, and every effort will be made to consult me beforehand should any disclosures be deemed necessary.
- I further agree that should I become incapable of giving consent for disclosure of essential medical information in the event of an emergency, information may be imparted at the discretion of the medical team acting in my best interests.
- On return from the expedition, I consent to my GP being contacted with details of any serious illness or accident arising during the course of the expedition.
- I agree to discuss with the doctor and/or expedition leader any injury or illness occurring between this date and the date of departure.

Expedition member signature: Date:

Medical Practitioner signature: Date:

Contact details of Medical Practitioner:

Name:

Address:

Telephone: Email: