

MEDICAL INFORMATION FORM



You must complete this Medical Information Form in full before we will accept your booking.

If this MIF is completed prior to June 1, 2021, we will give you provisional medical approval on the basis of the information provided in this MIF (and Guest Medical Report if applicable), but you will be required to reconfirm the details and advise ALE of any changes to your MIF at least 90 days prior to departure. Any significant medical changes may require you to seek a second Guest Medical Report and final medical approval will be dependent on this report.

Guest Medical Report (GMR): ALE’s Medical Director may send a follow up letter to your personal physician in the event that more information is necessary. The Report from your physician is intended to involve him/her in our medical process and confirm that your chosen experience is best suited to your current health conditions. Our goal is to identify any medical concerns early so we can ensure you have a safe and enjoyable experience while in Antarctica.

If you have any medical issues that may affect your fitness to participate, you are advised to seek advice from your own physician. The ALE Medical Director is freely available to discuss any issues you have concerning your health in Antarctica.

How we use the information:

Your answers will provide our medical officers with essential information to make any necessary or special preparations and to provide you with the best medical care as is possible in Antarctica if required. To this end, if you answer “Yes” to any question please give the fullest possible details.

Who sees the information:

Our administrative staff will receive and forward your information to the ALE Medical Director for review.

All information received is confidential and securely stored. However, any or all of it may be shared with your guide, other company personnel or third parties, if this is deemed necessary for your or others’ safety and well-being.

Family or Surname: _____	Given Names: _____
Experience Name: _____	Experience Date (Day/Month/Year): _____
Your Height (cm): _____	Weight (kg): _____
Date of Birth (Day/Month/Year): _____	Age: _____
Sex (Male/Female): _____	

CORONAVIRUS (ALSO KNOWN AS COVID-19 OR SARS-COV-2)

Have you at any time had a positive test for coronavirus?	NO	YES
If YES to the above, when?		
Was this test:		
an oral or throat swab	NO	YES
a saliva test	NO	YES
a blood test	NO	YES
Have you received hospital treatment for COVID-19?	NO	YES

PAST MEDICAL CONDITIONS

Have you at any time had any significant medical, surgical or mental health conditions? NO YES

If YES, please give details.

PRESENT MEDICAL CONDITIONS

Do you have any physical or mental health conditions requiring treatment or medical supervision? NO YES

If YES, please give details.

Have you undergone any surgical procedures in the last year? NO YES

If YES, please give details.

Have you had any hospital investigations or treatment in the last year? NO YES

If YES, please give details.

MEDICATION

Are you taking any drugs or medications, whether prescribed by a physician or not? This includes anti-coagulants (blood thinning drugs) or chemotherapy? NO YES

Drug (Chemical Name)

Dose

Reason

ALLERGIES – FOOD

Do you have any allergies to food? NO YES

If YES to the above, please give details.

To what are you allergic?

What symptoms do you have? (eg. lip/mouth/throat swelling, breathlessness, rash)

Have you ever been hospitalized for an allergic reaction? NO YES

Have you been advised to carry adrenaline (epinephrine)? NO YES

Have you ever received an adrenaline (epinephrine) injection? NO YES

ALLERGIES – MEDICATIONS AND OTHER

Do you have any allergies to medication or drugs? NO YES

Do you have any allergies to anything else? (e.g. latex) NO YES

If YES to either of the above, please give details.

To what are you allergic? _____
 What symptoms do you have? (eg. lip/mouth/throat swelling, breathlessness, rash)

Have you ever been hospitalized for an allergic reaction? NO YES

Have you been advised to carry adrenaline (epinephrine)? NO YES

Have you ever received an adrenaline (epinephrine) injection? NO YES

DAILY LIVING

Do you have any physical limitations or disabilities? NO YES

Do you use any artificial aids? (e.g. wheelchair, stick, prosthetic) NO YES

Do you have any special personal hygiene or toilet requirements? NO YES

Are there any daily living tasks that you are unable to perform? NO YES

If YES to any of the above, please give full details.

Do you have, or have you ever had:

Angina (Heart)	NO	YES	Thyroid Disease	NO	YES
Myocardial Infarct (Heart Attack)	NO	YES	Bleeding Disorders	NO	YES
High Blood Pressure	NO	YES	Depression	NO	YES
Other Heart Disease	NO	YES	Other Mental Health Condition	NO	YES
Cardiovascular Accident (Stroke)	NO	YES	Alcohol- or Drug-Related Problems	NO	YES
Transient Ischaemic Attack	NO	YES	Cancer	NO	YES
Peripheral Vascular Disease	NO	YES	Altitude Illness	NO	YES
Asthma	NO	YES	Back Problems	NO	YES
Epilepsy	NO	YES			

If YES to any of the above, please give full details (continue on extra pages if necessary).

The following sections are for different experiences.
You need only complete the relevant section for your particular experience.

SOUTH POLE FLIGHTS, EMPEROR PENGUINS & ANTARCTIC ODYSSEY EXPERIENCES

Do you have difficulty or get out of breath climbing 20 steps?	NO	YES
Do you have difficulty climbing a step-ladder?	NO	YES
Do you have any difficulties getting dressed or tying boot laces?	NO	YES
Do you have difficulty walking over uneven ground?	NO	YES
Do you have any difficulty crawling on hands and knees?	NO	YES

If YES to any of the above, please give full details (continue on extra pages if necessary).

Do you do any regular physical activity?	NO	YES
Have you ever slept in a mountain tent before?	NO	YES
What is the highest altitude you have ever been to? _____	In what year? _____	
How far can you comfortably walk on level ground without stopping? _____		

ALL CLIMBING, SKIING, SKYDIVING, & RUNNING EXPERIENCES & ALL EXPEDITIONS

ALTITUDE

What is the highest altitude you have ever climbed to? _____	In what year? _____	
What is the highest altitude you have climbed to in the past 3 years ? _____		
Do you intend to use Diamox (acetazolamide), e.g. on your ascent?	NO	YES
Have you ever had altitude illness (Acute Mountain Sickness/ High Altitude Pulmonary Edema/High Altitude Cerebral Edema)?	NO	YES

If YES, please give full details.

At what altitude did you become ill? _____		
Did you take or receive any drugs or other medical treatment?	NO	YES
If yes please give details.		
Did you need to descend?	NO	YES
If YES, how far did you descend until you recovered? _____		

COLD INJURY

Have you ever had frostbite or other cold injury?

NO

YES

If YES, please give full details.

When did this occur? _____

Where were you? _____

If on a mountain, what elevation were you at? _____

Which part of the body was affected? _____

What treatment was received? _____

Did you suffer any tissue loss? NO YES

Did you have any other lasting effects? NO YES

If YES to either of the above, please give full details.

FOR ALL EXPERIENCES & ALL EXPEDITIONS

If you have any medical issues that may affect your fitness to participate you are advised to seek advice from your own physician. The ALE Medical Director is freely available to discuss any issues you have concerning your health in Antarctica.

Details of your personal physician

Name: _____

Street Address: _____ **City:** _____

Country: _____ **Post Code:** _____

Phone: + _____ (Please give country code)

Fax: + _____

Email: _____

SIGNATURES

Please sign below. Your signature confirms:

- that you have read your experience guidelines and are fit to undertake your chosen experience;
- that you have provided accurate and complete information;
- your consent for ALE to seek further medical information from your personal physician;
- that you will inform ALE of any change in your medical details prior to the start of your experience;
- that you agree to undergo a medical examination if required by ALE either before or during your experience; and
- the right of ALE to adapt or curtail your experience due to medical circumstances.

Medical consultations with an ALE doctor remain strictly confidential. However, in exceptional circumstances only, information from these may be shared with your guide, other company personnel or third parties, and your signature confirms your consent to this.

SIGNED:

DATE:

Parent or Guardian must also sign this form if participant is under age of majority. (18 years in most countries.)

SIGNED:

DATE:

TO BE COMPLETED AFTER JUNE 1, 2021

<input type="checkbox"/>	I certify that the details provided on my original MIF are still accurate and unchanged.
<input type="checkbox"/>	I have made changes to this form.

SIGNED:

DATE:

Parent or Guardian must also re-sign this form if participant is under age of majority. (18 years in most countries.)

SIGNED:

DATE:
