

**MEDICAL INFORMATION FORM**  
**(Confidential)**

**THE PURPOSE OF THE MEDICAL INFORMATION FORM IS  
TO IDENTIFY POTENTIAL HEALTH PROBLEMS THAT COULD  
LEAD TO SEVERE INJURY OR EVEN DEATH IF  
UNIDENTIFIED.**

**FOR RELEASE OF INFORMATION**

The undersigned hereby authorize(s) any medical provider of the Participant listed below, including specifically the Survive & Thrive Expeditions staff and contractors, to use and to disclose the Participants clearance and health records, information and recommendations to the participant's: parents/legal guardians, other medical providers, Survive & Thrive Expeditions directors and staff to inform them of the participant's health status for involvement in activities with Survive & Thrive Expeditions and to provide emergency medical treatment.

**GRANTING OF CONSENT IN CASE OF MEDICAL EMERGENCY**

In case of medical emergency, I authorize the staff of Survive & Thrive Expeditions to arrange for such medical treatment involving the below named participant as is deemed necessary by the supervising physician and to provide on my behalf all necessary consents for such medical treatment. I authorize any consent(s) for such medical treatment as may be deemed necessary and this shall constitute granting of consent. I hereby give permission to the physician selected by the Survive & Thrive Expeditions staff to hospitalize, to secure proper treatments for, and to order injection, anesthesia or surgery for the below named participant. (These services will be obtained for the participant and charged to the participant's Travel Insurance Plan or equivalent). This shall constitute my consent for such treatment, injection, anesthesia or surgery as may be required in the opinion of the physician.

I understand that my refusal to sign this authorization may affect the Participant's ability to be involved in adventure activities organized by Survive & Thrive Expeditions.

**Participant Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## **MEDICAL INFORMATION**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

PROVINCE: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

HEALTH CARE #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

TRAVEL MEDICAL INSURANCE PROVIDER: \_\_\_\_\_

POLICY #: \_\_\_\_\_ INSURANCE CONTACT PHONE #: \_\_\_\_\_

EMERGENCY CONTACT #1: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_

Contact Phone Numbers: \_\_\_\_\_ (Home)

\_\_\_\_\_ (Work/Cell)

EMERGENCY CONTACT #2: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_

Contact Phone Numbers: \_\_\_\_\_ (Home)

\_\_\_\_\_ (Work/Cell)

**IF NOT ENOUGH SPACE IS PROVIDED TO EXPLAIN THE FOLLOWING QUESTIONS IN APPROPRIATE DETAIL PLEASE USE A SEPARATE SHEET OF PAPER AND ATTACH IT TO THE BACK OF THIS FORM.**

### **Cancer History**

**Type of Cancer:** \_\_\_\_\_ **Date of diagnosis:** \_\_\_\_\_

Lymph nodes involved? No \_\_\_ Yes \_\_\_ if yes, location? \_\_\_\_\_

Recurrence : No \_\_\_ Yes \_\_\_

Bone metastasis: No \_\_\_ Yes \_\_\_ Location : \_\_\_\_\_

Brain metastasis: No \_\_\_ Yes \_\_\_

Other metastasis: No \_\_\_ Yes \_\_\_ Location : \_\_\_\_\_

Lymphedema? No \_\_\_ Yes \_\_\_ If yes have you consulted a specialist? No \_\_\_ Yes \_\_\_

Do you have a sleeve/glove? No\_\_\_\_ Yes\_\_\_\_

**Surgical History:**

Cancer surgery: No\_\_\_\_ Yes\_\_\_\_ Pending \_\_\_\_ If pending, when? \_\_\_\_\_

Type of surgery : \_\_\_\_\_ Date of last surgery: \_\_\_\_\_

**CURRENT & FUTURE Treatment :**

Are you **newly diagnosed** and awaiting a treatment plan? No\_\_\_Yes\_\_\_

**Currently** undergoing *chemotherapy*? No\_\_\_\_ Yes\_\_\_\_

Types of chemotherapy: \_\_\_\_\_

Number of cycles completed:\_\_\_\_\_ Date of last treatment: \_\_\_\_\_

**Currently** undergoing *radiotherapy* : No\_\_\_\_ Yes\_\_\_\_

Number of treatments completed:\_\_\_\_\_ Date of last treatment: \_\_\_\_\_

**Current** complications due to treatment (infection, blood counts, muscle/bone/joint pain etc.):

---

---

---

**Completed Treatments:**

( ) Chemotherapy - Type : \_\_\_\_\_ Number of Treatments : \_\_\_\_\_

Date completed : \_\_\_\_\_

( ) Radiotherapy - Number of Treatments : \_\_\_\_\_

Date completed : \_\_\_\_\_

( ) Immunotherapy - Type of Treatment : \_\_\_\_\_

Date Completed : \_\_\_\_\_

( ) Hormone Therapy - Type : \_\_\_\_\_

Date started/duration : \_\_\_\_\_

( ) Other \_\_\_\_\_ Type of Treatment : \_\_\_\_\_

Date Completed : \_\_\_\_\_

## Medical History

**Allergies:** Explain and list below

- Environmental (e.g. dust, smoke, hay fever, insects, animals, etc.)  
 Medications (Carry an epipen?)

---

---

**Current Medications:**

- Prescriptions: (list)

---

---

---

- Over the counter/Herbal/Supplements:

---

Are there medications which must be kept with you at all times?

No\_\_\_\_ Yes\_\_\_\_ If yes, for what condition: \_\_\_\_\_

Name of medication(s): \_\_\_\_\_

- Are there any side effects or special concerns with taking your prescriptions?  
(describe)

---

---

**Injuries:** - check appropriate boxes if you have had any of the following injuries and explain in the space provided below:

- |                                      |                                  |                                   |  |
|--------------------------------------|----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Fingers | <input type="checkbox"/> Ankles   | <input type="checkbox"/> Fractures     |
| <input type="checkbox"/> Wrist       | <input type="checkbox"/> Knees   | <input type="checkbox"/> Back     | <input type="checkbox"/> Dislocations  |
| <input type="checkbox"/> Hip         | <input type="checkbox"/> Ribs    | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Other (list): |
| <input type="checkbox"/> Neck        | <input type="checkbox"/> Elbow   | <input type="checkbox"/> Feet     |  |

---

---

---

---

**Medical Illness:** - check the appropriate boxes if you have experienced any of the following apart from temporary conditions while on cancer treatments and explain in the space provided below:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Mumps                       | <input type="checkbox"/> Frequent Heartburn                | <input type="checkbox"/> Arthritis                        |
| <input type="checkbox"/> Mononucleosis               | <input type="checkbox"/> Intestinal Problems               | <input type="checkbox"/> Frequent Anxiety                 |
| <input type="checkbox"/> Chicken Pox                 | <input type="checkbox"/> Recent Weight Gain or Loss        | <input type="checkbox"/> Depression                       |
| <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Eating Disorder                   | <input type="checkbox"/> Irregular Menstruation           |
| <input type="checkbox"/> Positive HIV test           | <input type="checkbox"/> Shortness of Breath with Exercise | <input type="checkbox"/> Hearing Impairment               |
| <input type="checkbox"/> Heart Murmur                | <input type="checkbox"/> Exercise Induced Asthma           | <input type="checkbox"/> Visual Impairment                |
| <input type="checkbox"/> Palpitations                | <input type="checkbox"/> Allergy Induced Asthma            | <input type="checkbox"/> Recurrent Headaches              |
| <input type="checkbox"/> Irregular Heart Beat        | <input type="checkbox"/> Recurrent Colds                   | <input type="checkbox"/> Epilepsy                         |
| <input type="checkbox"/> Dizziness                   | <input type="checkbox"/> Sinus Problems                    | <input type="checkbox"/> Head Injury with Unconsciousness |
| <input type="checkbox"/> Sun Sensitivity             | <input type="checkbox"/> Kidney Disease                    | <input type="checkbox"/> Other (describe):                |
| <input type="checkbox"/> Blacking Out Episodes       | <input type="checkbox"/> Diabetes                          |   |
| <input type="checkbox"/> Activity Related Chest Pain |  |   |
| <input type="checkbox"/> Stomach Ulcer               |  |   |

---

---

---

---

**Any chronic conditions as a result of your treatments (If so what is done daily or on a regular basis to treat these conditions):**

---

---

---

---

**Will any of these medical conditions potentially affect your physical or mental abilities while on the river and if so what precautions will need to be taken to minimize this risk:**

---

---

**Surgical History:** - check the appropriate boxes if you have had any of the following:

- Hernia Repair     Tonsils     Appendix     Eye surgery  
 **Any Muscle/Bone/Ligament/ or Joint Surgery:** (describe)

---

---

---

**Personal/Social History:**

- Smoke - packs per day? \_\_\_\_\_  
 Alcohol Use (check most appropriate box):  Never  Rarely  Occasionally  Frequently  
 Special Diets (e.g. vegetarian, low carb, high protein, etc.) Explain:

---

---

---

**Family Medical History:** - check appropriate boxes if anyone in your family has had one of the following and explain below:

- Heart Attack                       Kidney Disease                       Severe Allergies or  
 High Blood Pressure               Cancer of any kind                       Asthma  
 Sudden Death

---

---

**Is the participant under any form of treatment/medication for any illness, condition or injury not yet addressed in this form?     Yes     No**

If yes, please explain:

---

---

Will this condition limit or affect participation in activities?     Yes     No

If yes, please explain:

**THE REMAINDER OF THE FORM IS TO BE COMPLETED BY YOUR FAMILY DOCTOR OR ONCOLOGIST**

**TARGETED PHYSICAL EXAMINATION**

**As the physician filling out the pre-expedition medical for this participant, please report on the exam findings listed below as well as any additional physical exam elements that you feel are indicated based upon the patient's medical history.**

PARTICIPANTS NAME: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

**VITALS:** BP \_\_\_\_\_/\_\_\_\_\_ Resting Pulse: \_\_\_\_\_

**ENT:** Visual Acuity L/20 \_\_\_\_\_ R/20 \_\_\_\_\_

Pupils L \_\_\_\_\_ mm R \_\_\_\_\_ mm

Other: \_\_\_\_\_

**CHEST:** Heart Sounds \_\_\_\_\_

Murmurs \_\_\_\_\_

Breath Sounds \_\_\_\_\_

Other: \_\_\_\_\_

**Other physical exam findings (either positive or negative) based upon the medical history provided to you by the participant:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Pertinent Investigations/Consultant Notes:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other Comments:**

\_\_\_\_\_  
\_\_\_\_\_

**Based on your history and examination, do you feel this participant is fit to travel and be active? ( ) Yes ( ) No**

**Physician's Name (Print):** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### **PARTICIPANT DECLARATION**

**I DECLARE THAT THE INFORMATION DISCLOSED ON THIS FORM IS COMPREHENSIVE AND AN ACCURATE DISCLOSURE OF MY MEDICAL HISTORY AND CURRENT CONDITION. I ACCEPT RESPONSIBILITY FOR PROVIDING THIS INFORMATION.**

**I, the participant named above, will endeavor to contact Mike Lang (Expedition Leader) if any changes occur in my health status between now and the commencement of the expedition.**

**Participant Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_