Expedition Health Form

Antarctica

Consent and Authorization

It is important that Wharton Leadership Ventures and its external venture providers be made aware of medical or emotional issues, past or current, as even mild physical or psychological conditions can become serious under the stresses of life in an unfamiliar environment.

The information provided by you and your physician(s) will remain confidential. By signing below, you consent to the information being shared with Wharton Leadership Ventures program staff, your venture provider, and other appropriate professionals, if pertinent to your well-being or your participation in the venture program.

You also authorize by your signature below the release of any medical information that may be relevant in the opinion of your health care provider to your participation in this external venture program.

Your Signature: _____

Date: _____

Medical Form / All information provided is confidential

Please complete and return to Wharton Leadership Ventures
G36 Huntsman Hall 3730 Walnut St, Philadelphia, PA 19104 1

	IMPORTANT INFORMATION: - Doctor and Participant to read before
1	Prospective participants will only be accepted on a Vertical S.A. venture with this Medical Examiner's report recommending acceptance. If the participant is not considered fit, the Medical Examiner should not recommend the participant be accepted.
2	Medical Examiner is requested to make a full and complete examination of the applicant and document their medical history.
3	Vertical ventures can be both physically and emotionally demanding. Ventures vary from 8 to 14 days. Activities include include trekking, climbing, camping and kayaking in all weather conditions.
4	Full disclosure of medical history is necessary for the participant's and others' safety.
5	Medical problems will not necessarily exclude a prospective participant from a venture, unless indicated, as long as the condition can be appropriately managed.
6	This medical report is valid for **three** months from the date completed by a medical doctor and must be valid for the duration of the venture dates.
	This Medical must be valid from_____to_____.

Pages 1, 2 and 3 (sections 1 - 4) must be completed.
Page 4 and 5 contains additional information to be completed by Doctor if participant has a history of mental illness and/or asthma.

Section 1 Participant Details (Please print your answers neatly)			
Surname		First Name(s)	
Date of Birth		Age	
Phone 1		Phone 2	
email 1		email 2	
Minimum Fitness Requirement			
Can you comfortably run three kilometres in less than 25 minutes *Please note that if you are unable to meet this minimum requirement you may be asked to leave the course*		YES	NO
Can you swim 20 meters with confidence?		YES	NO
Do you smoke? If Yes, How many per day?		YES	NO

Medical Form / All information provided is confidential

	Declaration:
1	I declare that the information given in this form is true and complete to the best of my knowledge.
2	I understand that if I have not disclosed all previous medical conditions or injuries, or if I receive an injury after signing this medical form and do not disclose this to Vertical before the start of the venture, and these conditions or injuries limit or exclude me from the Venture I will not be entitled entitled to a refund.
3	The safety and well being of participants on an Vertical venture is the first concern of the Vertical Trust. However, I understand that all participants take part at their own risk and must accept personal liability for any injury.
4	I authorize Vertical to contact the Medical Examiner who gave this report to obtain further information that may be required.
5	I acknowledge that in accordance with the provisions of the Privacy Act 1993 the following information has been brought to my attention: a) This form collects personal information about me. b) The information is collected to evaluate my suitability to attend a Vertical venture. c) The intended recipients of the information are those staff directly involved with my attendance at Vertical Venture. d) The information is being collected and held by Vertical. e) The Privacy Act 1993 entitles me to have access to and request a correction of the information.

Signature_____ Date_____.

	Section 2, Medical History - to be completed by Doctor			
	Has the applicant had any of the following?	YES	NO	If YES please add details
1	Asthma			If 'yes' to 1 please complete section 6: Asthma
2	Epilepsy (Must be seizure free for past 12 months, provide letter outlining history of epilepsy)			Additional Information.
3	Mental Illness. (Depression, Anxiety, Eating Disorders, Substance Abuse or other.)			If 'yes' to 3, 4 and 5 please complete section 7: Additional Information (Mental Illness and Behavioral)
4	Suicidal thoughts /attempts or self harming behaviors.			
5	Any conduct behavioral issues (ie ADHD			
6	Any learning difficulties. (Low IQ, dyslexia ?)			
7	Any recent traumatic experiences or death of relative or friend in past 12 months.			
8	Any allergy (stings, food, medicine) Inc. details			
9	Any heart conditions (Please seek approval from specialist if currently under care of one)			
10	Fainting attacks, blackouts			
11	Migraine			
12	Diabetes. HbA1c <8.0 in last 3 months is required			

	Section 2, Medical History - to be completed by Doctor			
13	Hepatitis, HIV or AIDS related condition			
14	Head Injury, concussion, unconsciousness			
15	Backache, spinal injury, disc trouble			
16	Any knee, ankle or joint injury			
17	Any other serious illness, injury, operation or condition?			
18	Have you ever had altitude illness (AMS/HAPE/HACE)?			If 'yes' to 1 please complete section 5: Altitude illness
19	Currently pregnant. If 'yes" this excludes a student from attending			

Section 3 Medical Examination - to be completed by Doctor **N: Normal - A: Abnormal**								
Cardiovascular System	N	A	Hearing	N	A	Central nervous system	N	A
Abdomen	N	A	Current mental status	N	A	Vision	N	A
Locomotor system	N	A	Respiratory system	N	A	Ears	N	A
Height (cm)			Weight (Kg)			Resting HRate		
Blood			Date of last tetanus booster					

Section 4. Medical Examiner's Report			
Examiners Name			
Adress			
Are you the applicants regular doctor?	YES	NO	Phone
As a Registered Medical Practitioner, I have read the general information on the front of this medical form and I can certify that the health fitness of this applicant is:			
Blood		Date of last tetanus booster	
Satisfactory - Applicant should be accepted	YES	Not Satisfactory - Applicant should not be accepted	NO
Signature_____ Date_____.			

Vertical S.A.
Av. Los Leones #1776, Providencia – Santiago – Chile
Teléfono: (56-2) 2232100 – Fax: (56-2) 2098735

If you do not require this page, please return it with your completed medical form so it can be recycled

Section 5. Altitude illness		
At what altitude were you ill?		
Did you take or receive any drugs or other medical treatment?		
Did you need to descend?	YES	NO
If so, how far did you descend until you recovered?		

Section 6. Asthma additional Information			
It is important to note that there is a wide range of conditions that individuals on the course will be exposed to that could trigger asthma: these include vigorous exercise, warm/cold weather, damp weather and allergens.			
Year asthma diagnosed:		Triggers	
Frequency of exacerbations		Peak Flow Readings	
No of times emergency room treatment in last 2 yrs		Best peak flow	
Date of last attack requiring emergency room treat.		Expected peak flow	
Dates of asthma attacks requiring hospitalization		Current peak flow	
Asthma Medication			

	Medication	**Dosage**	**Frequency**	**Last used**
Reliever				
Preventer				
Other e.g. prednisone				

Section 7. Mental Illness & Behavioral additional Information			
We at Vertical S.A. are very concerned about the students physically and mental health. We use the outdoors and the activities as a medium for individuals to challenge themselves and to think about their behaviors and lives. We ask people to go outside their comfort zones mentally and physically and at times the course can be very demanding. For this reason we ask for more information to support the application of anyone who has a history of depression, attempted suicide or mental illness. This information must be from a specialist who has worked with the individual. Our aim is to ensure that individuals who start the program are mentally fit and will be capable of attending and completing the programe safely.			
What is/was the condition?			
What are the circumstances and/or what precipitated the condition?			
How long did it last? (please include dates)			
When were the most recent symptoms of the condition?			
How was the condition treated?			
Medication (please print clearly)	Dosage		Date discontinue
What is the current state?			
Has this person ever been suicidal or attempted suicide?	YES	NO	Please give details? include dates and current state
Has this person displayed aggressive or violent behavior?	YES	NO	Please give details? include dates and current state

I certify that:			**is**
Suitable		Not Suitable	
To attend a Vertical Venture			
Medical Examiner´s signature			
Date			