Expedition Health Form | MBA

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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: _____

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

How we use the information:
Your answers will provide our Medical Staff with essential information to make any necessary or special preparations and to provide you with as good medical care as we can during the program if required. To this end, if you answer "YES" to any question please give the fullest possible details.

Who sees the information:
All information received is confidential and securely stored. However, any or all of it may be shared with your guide, other company personnel, if this is deemed necessary for yours and others' safety and well-being.

IMPORTANT INFORMATION: - Participant to read before	
1	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.
2	Full disclosure of medical history is necessary for the participant's and others' safety.
3	Medical problems will not necessarily exclude a prospective participant from a venture, unless indicated, as long as the condition can be appropriately managed.
4	This Medical Information Form is valid for **three** months from the date completed
	This Medical Information Form must be valid from_____ to _____.

Family or Surname		Given Names	
Your Heigh (cm)		Weight (kg)	
Date of Birth (day/Month/year)		Age	

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 acknowledge that in accordance with the provisions of the Privacy Act 1993 the following information has been brought to my attention: I. This form collects personal information about me. II. The information is collected to evaluate my suitability to attend a Vertical venture. III. The intended recipients of the information are those staff directly involved with my attendance at Vertical Venture. IV. The information is being collected and held by Vertical. V. The Privacy Act 1993 entitles me to have access to and request a correction of the information.
Signature	Date .

Past Medical Conditions

Have you had any significant medical, surgical or mental health conditions? If YES, please give details	**NO**	**YES**

Present Medical Conditions

Do you have any physical or mental health conditions requiring treatment or medical supervision? If YES, please give details	**NO**	**YES**

Have you undergone any surgical procedure in the last year? If YES, please give details	**NO**	**YES**

Have you had any hospital investigations or treatment in the last year? If YES, please give details	**NO**	**YES**

Medication: Are you taking any drugs or other medication, including anti-coagulants, or receiving chemotherapy	**NO**	**YES**
Drug (generic name)		
Dose		
Reason		
Extra information		

Allergies: Do you have any allergies? If YES, please provide details	**NO**	**YES**
What are you allergic to? / Mild/Moderate/Severe		

Do you have, or have you ever had:		
Angina (cardiac)	NO	YES
Myocardial Infarct (heart attack)	NO	YES
High Blood Pressure	NO	YES
Other Heart disease	NO	YES
Cardiovascular accident (stroke)	NO	YES
Transient ischaemic attack	NO	YES
Peripheral vascular disease	NO	YES
Asthma	NO	YES
Epilepsy	NO	YES
Thyroid disease	NO	YES
Bleeding disorders	NO	YES
Depression	NO	YES
Other mental health condition	NO	YES
Cancer	NO	YES
Altitude illness	NO	YES
Back problems	NO	YES

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

Disabilities:		
Do you have any physical limitations or disabilities?	**NO**	**YES**
Do you use any artificial aids, e.g. wheelchair, stick, prosthetic	**NO**	**YES**
If YES to any of the above, please give full details		

Altitude		
What is the highest altitude you have ever climbed to?		
What year was this?		
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 (AMS/HAPE/HACE)?	NO	YES
If YES, please give details:		
At what altitude were you ill?		
Did you take or receive any drugs or other medical treatment?		
Did you need to descend?	NO	YES
If so, how far did you descend until you recovered?		
Have you ever had frostbite or other cold injury?	NO	YES
If YES, please give details:		

If you have any medical issues that may affect your fitness to participate you are advised to seek advice from your own physician.

Details of your personal Physician	
Name	
Street Address	
City:	
Country:	
Phone (Please give country code)	
Email:	

OTHER AUTHORIZED CONTACT (We may be asked for information about you while you are in the programe. We will ONLY give information to people you specify. You may wish to list a spouse, friend, work contact, or your travel agent)					
Name		Relationship:		Contact info	
Name		Relationship:		Contact info	
Name		Relationship:		Contact info	

Please sign below. Your signature confirms:

1 that you have read your program guidelines and are fit to undertake your chosen expedition;

2 that you have provided accurate and complete information;

3 your consent for Vertical to seek further medical information from your personal Physician;

4 that you will inform Vertical of any change in your medical details prior to the start of your program;

SIGNED ……

DATE……..