MEDICAL QUESTIONNAIRE

It is for your own safety that we find out as much as possible about your medical history , to ensure that your can cope with the rigours of your challenge, and so that we can take good care of you whilst on the event. Your answers will be treated in the strictest confidence and will not necessarily adversely affect your chance to take part. Any decisions will be made in consultation with you. The information you supply is strictly confidential and will only be used in relation to your challenge.

1. Your Name & Address:

2. Do you suffer from, or have you ever suffered from: (please circle)

Condition		
Asthma or wheezing (with breathing or exercise)	YES	NO
Severe attacks of hay fever / allergy	YES	NO
Any form of lung disease	YES	NO
Cancer	YES	NO
Chest surgery	YES	NO
Claustrophobia or agoraphobia	YES	NO
Behavioural health problems	YES	NO
Epilepsy, seizures or convulsions	YES	NO
Recurring migraine headaches	YES	NO
Blackouts or fainting	YES	NO
Motion sickness	YES	NO
Recurrent back problems / surgery	YES	NO
Diabetes	YES	NO
Arm or leg problems	YES	NO
High blood pressure	YES	NO
Any heart disease / heart attacks	YES	NO
Angina / heart surgery or blood vessel surgery	YES	NO
Hearing loss or problems with balance	YES	NO
Bleeding or other blood disorders	YES	NO
Any type of hernia	YES	NO
Ulcers or ulcer surgery	YES	NO
Bowel disorder	YES	NO
Drug or alcohol abuse	YES	NO
Have you been in hospital in the last year?	YES	NO
Are you awaiting tests / investigations / results	YES	NO
Do you regularly take prescription medication? NB. Disregard contraceptive pill for this question	YES	NO
Are you pregant?	YES	NO
Are you registered disabled?	YES	NO
Do you suffer from phobias (heights, flying, water)?	YES	NO
Are there any other medical issues not covered above which are relevant to your well being ?	YES	NO

3. If you have answered yes to any of these questions, please give further details below or on a separate sheet:

4. Please list any medications you are currently taking and ensure you bring enough supplies (in the original container) for the length of the trip:

5. Are you Diabetic? YES NO
   Please delete as appropriate

   If YES - please give details beolow

DECLARATION

I confirm that I have understood the need for fitness and to the best of my knowledge this is a true and accurate description of my medical history.

˝ I understand that the challenge will involve strenuous activity and that I need to achieve an adequate level of fitness in order to participate in the challenge that I have selected. Before the departure of the challenge, if I have any concerns whatsoever about my physical fitness or health, or any of the medical conditions listed that may affect my safe participation, I will consult my doctor.

˝ I hereby certify that the information provided by me on this form is to the best of my knowledge true and correct.

˝ I understand that if any of the information provided by me on this form is found to be false, I risk losing my place on the challenge.

Signed

Date

Name (Capitals)

If you are 65 years or older, or have answered YES to any of the questions on this form, this section must be completed by your doctor who has access to your medical history.

The above named person will be participating in a strenuous challenge. They will trekking for approximately 8 hours a day over rough terrain, in extremes of temperature, climate and altitude. The participant may be camping with basic facilities such as earth toilets, primitive washing facilities and living under canvas. They will be eating a different diet to what they are used to. The tour operator will provide English speaking first-aid qualified guides, or an English speaking doctor to give immediate medical assistance at all times. Please note however that the event may be a considerable distance from any hospital support. With the above information, if there is any matter that you feel the organisers should be aware of, please supply details on a separate sheet.

If you need any further information, please call **Great Walks of the World:- Tel 01935-810820**

I have read the above paragraph and agree that the participant's medical details are correct. In my opinion this patient is fit and healthy both physically and mentally, and is able to to participate in this event.

Surgery Stamp

Doctor's Signature

Date

Doctor's Name (Capitals)

Address

GMC Number

This page can be photocopied prior to completion, if required.

Please return this form to: **Sabrina Simpson**

Postal Address: Scottish Society for Autism
Hilton House, Alloa Business Centre
The Whins, Alloa FK10 3SA