CONFIDENTIAL MEDICAL REPORT BETWEEN FSA AND CLIENT

PERSONAL DETAILS (Participant to complete)

First Name: .... Surname: ....

Date of Birth: .... Medicare Number: ....

Do you have private health cover? **Y / N** If so which insurer? ....Ambulance cover? **Y / N**

EMERGENCY CONTACT INFORMATION (Participant to complete)

Person to contact in an emergency: ....Relationship?............................

Emergency contact number(s): H ....Mobile: ....

TREK / PROGRAM BACKGROUND & NOTES FOR DOCTOR

Please provide your professional opinion as to whether the client named above, is medically fit to participate in the activities described hereafter.

Please consider the results of clinical examination, medical history and current health & fitness status.

The nature of the activities they will be participating in is described here:

Free Spirit Adventures (FSA) takes clients on a variety of treks ranging from less challenging destinations which require moderate exercise and light weight backpacking through to more challenging and remote environments which can include steep terrain, humidity, altitude, extreme cold and in some cases carrying up to 20Kg. FSA provides a progressive physical conditioning program over 6-9 months to prepare people for the specific conditions they may encounter (starting with short walks and building up to multi-day walks with pack)

Please call FSA on 0421 598 465 if you need more information or consult www.freespiritadventures.com.au

DOCTOR'S PERMISSION TO ADMINISTER MEDICATIONS IN EMERGENCIES

Trek Leaders are trained in Wilderness First Aid/Remote Emergency Response and carry the following medications in their kit for remote locations. Trek leaders will only use medications that are appropriate for the circumstances and that have been permitted for use by the patient and their Dr. **Please review this list carefully and indicate clearly if there are any contraindications for administration of any medications to this participant?** Please Circle: OK / Not OK

						*Extreme Emergency Use		
Paracetamol	OK	Not OK	**Immodium**	OK	Not OK			
Aspirin	OK	Not OK	**Coloxyl**	OK	Not OK	***Zofran**	OK	Not OK
Ibuprofen	OK	Not OK	**Buscopan**	OK	Not OK	***Endone**	OK	Not OK
Panadeine	OK	Not OK	**Zyrtec**	OK	Not OK	***Asmol**	OK	Not OK

MEDICAL CONDITIONS & ASSESSMENT

(to be carried out by a qualified medical practitioner)

Please provide a clinical exam and note relevant history, medications (dose & admin regime) for this participant. Then consider your findings when providing your professional opinion as to whether they are medically fit to undertake the trekking activities described.

AGE: ....WEIGHT[kg]: ....HEIGHT[cm]: .... BMI: ....

RESPIRATORY SYSTEM **SMOKING HISTORY** (Please Circle) *Current* *Previous* *Never*

Conditions of concern: Asthma requiring oral steroids or nebuliser; COPD or other chronic pulmonary disorder with reduced pulmonary function...

History/Medications ....

Clinical examination: Normal / Abnormal Comments: ....

NB: Participants with severe asthma must carry sufficient Ventolin (or equivalent) while trekking.

CARDIOVASCULAR SYSTEM **FAMILY HISTORY** (close relative <65) *YES / NO*

Conditions of concern: Cardiovascular disease, especially ischaemic heart disease, cardiac arrhythmia, stroke and peripheral vascular disease, Hypertension; heart stents / bypass surgery; haemophilia / anaemia. **If CV Risk is considered to be high; do you recommend an Ex Stress Test?** ....

History/Medications ....

Clinical Results: BP: ....../....... Pulse: .... reg / irreg HS: normal / abnormal

If Stress Test or Blood tests required – note results here:...

MUSCULOSKELETAL SYSTEM

Conditions of concern: Back or joint injury or disorder, especially osteoarthrosis of hip / knee; arthritis / rheumatism; any dislocations or disorder of the feet / knees / hips / back / shoulders...

History/Medications:...

Clinical exam: Spine: Normal / Abnormal Joints: Normal / Abnormal Feet: Normal / Abnormal

NERVOUS SYSTEM

Conditions of concern: Any chronic neurological disorder causing impaired function; migraine that has resulted in absence from work; epilepsy (unless having ability to hold a drivers license, or have been seizure free for 2 years); severe sight or hearing impairment...

History/Medications:..

DIGESTIVE DISORDERS

Conditions of concern: Stomach trouble requiring medical attention; ulcers; reflux, digestive conditions, liver issues (previous malaria); appendicitis...

History/ Medications: ....

MEDICAL CONDITIONS & ASSESSMENT (cont)

METABOLIC DISORDERS

Conditions of concern: Unstable insulin dependent diabetes; type 2 diabetes with history of hypoglycaemia; obesity severe enough to impair fitness; kidney disorders; skin disorders...

History/Medications: ....

NB: All participants with insulin treated diabetes must carry a Hypokit (glucagon) on the program

PSYCHOLOGICAL HEALTH

Conditions of concern: Severe psychological disorder currently under treatment eg Panic disorder, major anxiety, major depression, psychosis, phobias...

History/Medications:..

HOSPITILISATION WITHIN THE LAST 12 MONTHS? YES / NO

Details: ....

AWAITING SURGERY / SURGERY THAT HAS BEEN RECOMMENDED BUT NOT YET CARRIED OUT?

YES / NO Details: ....

SPECIAL MEDICAL OR DIETARY REQUIREMENTS

....

GENERAL COMMENTS

....

VACCINATIONS

Please provide recommendations and/or prescriptions to the client for appropriate vaccinations that are relevant for high risk diseases associated with the destinations they will be visiting.

Eg; Malaria zones, high risk of Hep A, Typhoid, Cholera, Yellow Fever or other mandatory vacs

Recommendations: ....

LEGALLY QUALIFIED MEDICAL PRACTITIONER RECOMMENDATION

Based on my examination, the prospective participant's medical history, and keeping in mind the nature of the activities to be performed, the participant named ....is:

MEDICALLY FIT / MEDICALLY UNFIT

to attend and participate in the aforementioned activities. If unfit, please summarise the reason(s):

....

LQMP NAME: ....

LQMP SIGNATURE: ....**DATE:** ..../........../................

CONTACT ADDRESS & PHONE NUMBER: ....

ALLERGIES (Participant to complete)

Do you have any allergies of any kind? (eg bee stings, peanuts, medications, food intolerances etc)

YES / NO

If so, how severe is your allergy and what treatment do you normally require?

....

NB: All participants with severe allergic reactions must carry 2 x Epipens on the program

SWIMMING ABILITY (Participant to complete)

Please indicate your swimming ability (circle best description): **POOR** **MODERATE** **STRONG**

DISCLAIMER TO BE COMPLETED BY PARTICIPANT

I .... understand that Free Spirit Adventures will take all necessary precautions to minimise risk as much as possible during my preparation, training and my adventure. However, I acknowledge and agree that all adventures have inherent risks that cannot in all cases be prevented by responsible risk management and therefore take responsibility for my own safety during the trip. Other than for negligent acts on behalf of the providers, I agree that Free Spirit Adventures and its staff shall not be liable for any loss, damage or injury to myself or my property.

In the event of a medical emergency I give permission to the provider to administer/arrange, at my expense; any medical treatment or emergency evacuation that may be deemed necessary. I declare that I have adequate insurance to cover medical emergency.

I am aware of no medical reason why I cannot participate in this adventure & preparation program.

I acknowledge that I have read and understood all information on this form and that it is true & correct.

Signature: ....Date: ..../.........../.............