MEDICAL FORM

Please complete this form if you have a medical condition that is important for a physician or crew on board the ship to be aware of. We ask you to complete this medical report in full, honestly and accurately. Should your medical situation change after submitting this form, it is your responsibility to advise us immediately. If you check any of the boxes below, we kindly ask you and your physician to complete and sign page 2. The deadline for submission is no later than 30 days prior to departure.

Ship name: _____ Embarkation date: _____

Your name: _____ Booking number: _____

Check all medical conditions for which you are currently under the care of a physician, or for which you have been under care in the past two years:

☐ Neurological - stroke, motor neuron diseases, multiple sclerosis, Parkinson's disease, polio, disorders of balance, seizures (epilepsy), dementia, memory disorders, intellectual impairment

☐ Musculoskeletal - joint replacements, muscle disorder (e.g. muscular dystrophy)

☐ Eyes - glaucoma

☐ Sensory - blindness, deafness, disorders of sensation (e.g. peripheral neuropathy)

☐ Physical - amputee, post trauma physical disabilities, post surgery physical disabilities

☐ Gastrointestinal - Crohn's disease, inflammatory bowel disease

☐ Heart - bypass surgery, angioplasty, stent, rhythm problems, pacemaker, heart failure

☐ Immune disorder - HIV, AIDS, steroid use

☐ Cancer - any type

☐ Lung - emphysema (COPD), severe asthma

☐ Mental Health disorders - bipolar disease, mania, schizophrenia, psychosis Endocrine - diabetes, thyroid

☐ Blood thinner - anticoagulants

☐ Pregnant, due date: _____

This section should be completed by your doctor. Please note that in an emergency this information will be given to all staff involved in your treatment.

Traveller's full name: _____

Name of physician: _____

Phone number: _____

Email: _____

Office address: _____

City: _____ Zip code: _____ Country: _____

Please list any current medical conditions, infirmities or disabilities.

_____

_____

_____

List all prescription medicines currently taken by this patient. If more space is needed, please attach a separate sheet.
(Trade name - Generic name - Dose strength - Frequency - Purpose) Enter N/A if the question does not apply.

_____

_____

_____

If this patient has been hospitalized or had surgery at any time during the last two years, please tell us when and why.

_____

_____

_____

Does this patient have mobility limitations? Please describe any mobility aids used by this patient.

_____

_____

_____

I confirm that the patient is fit to travel on an expedition cruise in the Polar Regions. For more information on the nature of the specific trip, please visit our website www.polarquest.se (swe) or www.polar-quest.com (eng).

Physician's signature: Date:

Patient's signature:
(or parent, for a minor) Date:

PolarQuest