

# MEDICAL FORM (IN CONFIDENCE WHEN COMPLETE)

EXPEDITION COUNTRY AND DATE

1<sup>ST</sup> CHOICE: \_\_\_\_\_

2<sup>ND</sup> CHOICE: \_\_\_\_\_

# Raleigh

## PERSONAL DETAILS

PLEASE COMPLETE THE FOLLOWING QUESTIONS

FIRST NAME: \_\_\_\_\_ FAMILY NAME: \_\_\_\_\_

DATE OF BIRTH (DAY/MONTH/YEAR) \_\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

STATE/PROVINCE: \_\_\_\_\_

COUNTRY: \_\_\_\_\_ POSTCODE/ZIP CODE: \_\_\_\_\_

DAYTIME TELEPHONE (INCLUDING INTERNATIONAL CODE): \_\_\_\_\_ EVENING TELEPHONE: \_\_\_\_\_

MOBILE/CELL/HANDPHONE: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

## PERSONAL MEDICAL HISTORY

- HAVE YOU EVER SUFFERED FROM A PSYCHIATRIC OR MENTAL DISORDER, INCLUDING DEPRESSION?  YES  NO
- HAVE YOU EVER SUFFERED FROM FITS, SEIZURES OR SEVERE HEAD INJURIES?  YES  NO
- HAVE YOU EVER HAD AN OPERATION UNDER GENERAL ANAESTHETIC?  YES  NO
- HAVE YOU BEEN HOSPITALISED WITHIN THE LAST 12 MONTHS?  YES  NO
- DO YOU SUFFER FROM ANY ALLERGIES? (INCLUDING DRUGS, HAYFEVER, ETC)  YES  NO
- DO YOU SUFFER FROM DIABETES?  YES  NO

IF 'YES' TO ANY OF THE ABOVE THEN PLEASE GIVE DETAILS AND DATES ON THIS FORM OR ON A SEPARATE SHEET. PLEASE ALSO GIVE DETAILS OF ANY FAMILY HISTORY OF THE ABOVE.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU EVER SUFFERED FROM ASTHMA?  YES  NO

WHEN WAS THE LAST TIME YOU NEEDED HOSPITAL TREATMENT? \_\_\_\_\_

\_\_\_\_\_

WHEN WAS THE LAST TIME YOU NEEDED STEROID TABLETS? \_\_\_\_\_

\_\_\_\_\_

WHAT MEDICATION / INHALERS DO YOU USE? \_\_\_\_\_

\_\_\_\_\_

## CURRENT HEALTH

DO YOU CURRENTLY USE ANY FORM OF MEDICATION REGULARLY? (INCLUDING BIRTH CONTROL PILLS)?

YES

NO

IF SO, PLEASE GIVE DETAILS:

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HAVE YOU EVER TAKEN ANTI-MALARIA TABLETS?

YES

NO

DID YOU HAVE ANY PROBLEM/SIDE EFFECTS?

YES

NO

IF TAKEN ANTI-MALARIA TABLETS, NAME WHICH ONES:

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DO YOU HAVE ANY PHYSICAL OR OTHER DISABILITY?

YES

NO

IF SO, PLEASE GIVE DETAILS AND DATES:

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ANY OLD INJURIES/ILLNESSES THAT ARE NOT DECLARED AND REOCCUR WHILST ON THE EXPEDITION WILL NOT BE COVERED BY RALEIGH'S INSURANCE. THIS HEALTH HISTORY IS CORRECT TO THE BEST OF MY KNOWLEDGE. IN THE EVENT OF ILLNESS OF ACCIDENT ON MY EXPEDITION, I HEREBY GIVE PERMISSION FOR RALEIGH MEDICAL OR OTHER EXPEDITION STAFF TO INITIATE MEDICAL TREATMENT AND INFORM MY NEXT OF KIN IN CASE OF HOSPITALISATION.

CANDIDATE'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**IF ANYTHING TO DO WITH YOUR PHYSICAL OR MENTAL HEALTH CHANGES AFTER RETURNING THIS FORM, YOU MUST INFORM THE MEDICAL COORDINATOR AT HEAD OFFICE.**

## TO BE COMPLETED BY FAMILY DOCTOR/PHYSICIAN WHO HAS ACCESS TO PATIENT'S MEDICAL HISTORY

THE ABOVE NAMED PERSON WILL BE PARTICIPATING IN A RALEIGH EXPEDITION DURATION DURING WHICH HE/SHE WILL BE SUBJECT TO BASIC LIVING CONDITIONS, HARSH PHYSICAL AND MENTAL STRESS AS WELL AS EXTREMES OF CLIMATE. THESE DEMANDS WILL INVOLVE BACK PACKING, BEING ABLE TO CARRY WEIGHTS OF UP TO 20KG, AND BEING FIT ENOUGH TO TREK IN CONDITIONS WHICH WILL INVOLVE POSSIBLE EXTREME TEMPERATURES, CLIMATE, ALTITUDE CHANGES AND ROUGH TERRAIN. PROJECTS WILL VARY FROM ON THE MOVE TO STATIC PROJECT SITES. THESE WILL PROVIDE VERY BASIC FACILITIES, SUCH AS LONG DROP TOILETS AND PRIMITIVE WASHING FACILITIES, AND THEY WILL BE LIVING UNDER CANVAS OR THE STARS.

THE DIET PROVIDED WILL BE DEHYDRATED FOOD AND FRESH VEGETABLES OR FRUIT, WHEN AVAILABLE, THIS BEING COOKED ON OPEN WOOD FIRES. RALEIGH AIMS TO PROVIDE A MEDIC (DOCTOR/NURSE) ON EACH PROJECT SITE TO GIVE IMMEDIATE FIRST AID AND ENSURE HIGH HYGIENE STANDARDS ARE TAUGHT AND MAINTAINED. THE PROJECT SITE CAN BE A CONSIDERABLE DISTANCE FROM ANY HOSPITAL BACK UP.

WITH THE ABOVE INFORMATION, IF THERE ARE ANY MATTER OF WHICH YOU FEEL THE MEDICS SHOULD BE AWARE, PLEASE SUPPLY ON A SEPARATE SHEET. IF YOU REQUIRE FURTHER DETAILS PLEASE CONTACT THE MEDICAL CO-ORDINATOR ON 020 7183 1291.

***"I HAVE READ THE ABOVE PARAGRAPH AND AGREE THAT THE CANDIDATE'S MEDICAL DETAILS ARE CORRECT. BASED UPON NOTES IN MY POSSESSION IN MY OPINION THIS PATIENT IS FIT AND HEALTHY, MENTALLY AND PHYSICALLY, AND ABLE TO PARTICIPATE IN A RALEIGH EXPEDITION"***

DOCTOR'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

DOCTOR'S NAME (IN CAPITALS): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

POSTCODE/ZIP CODE \_\_\_\_\_

DOCTORS STAMP AND GMC NUMBER: \_\_\_\_\_

**THIS FORM MUST BE SIGNED BY A DOCTOR AND RETURNED TO YOUR EXPEDITION SUPPORT CO-ORDINATOR AS SUPPORTING EVIDENCE FOR YOUR APPLICATION.**

**PLEASE SEND TO RALEIGH, THIRD FLOOR, 207 WATERLOO ROAD, LONDON SE1 8XD.**

**PLEASE CONTACT THE MEDICAL CO-ORDINATOR ON 020 7183 1291 IF YOU HAVE ANY QUERIES.**