Live The Dash Tours
traveling solo...together

LIVE THE DASH TOURS CONFIDENTIAL MEDICAL FORM

GENERAL INFORMATION

Who should complete this form?

All travelers must complete sections 'I' and 'II'. If you have indicated that you have a pre-existing medical condition you are also required to complete section 'III'. Live The Dash Tours asks that you provide as much information as possible in order for us to provide the best possible assistance in the unlikely event of a medical emergency.

Please note Live the Dash Tours will assess the information contained in this form, and we reserve the right to request a physician's assessment on any passenger.

Why do I need to complete this form?

Our tours can be to remote locations where limited or non-sophisticated medical facilities exist. A medical emergency situation is extremely unlikely; however, should it arise we will be armed with the information necessary to help you.

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What happens if I don't complete this form?

In the event you have made a booking with Live the Dash Tours and subsequently are unable or refuse to complete this medical form for any reason by the final payment date as specified in our terms and conditions, Live the Dash reserves the right to consider your booking cancelled as of that day and the applicable cancellation penalties will apply.

How do I complete this form?

It is very important for your own health and safety that you complete all questions fully and truthfully; we rarely have to refuse anyone a place on our tours for medical reasons, but in the event of a medical emergency, the information you provide can be crucial. Should any such condition become

apparent, we reserve the right to decline, accept or retain you or any other passenger at any time during the trip.
All travelers must complete, and return sections I & II.
If travelers answer yes to any question in section II (excluding question 5), then proceed to section III. Part 1 of section III must be completed by yourself, and Part II given to your medical practitioner to complete on your behalf. Each of you must then sign and return the entire document.

SECTION I – GENERAL INFORMATION – Please complete all fields

Name: _____ Booking Number: _____

Trip Name: _____ Departure Date: _____

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SECTION II– MEDICAL INFORMATION – Please complete all fields

1. During the last 5 years, have you suffered any significant illness, been hospitalized or required regular care by a doctor? ☐ Yes ☐ No
   If yes, please indicate reason: _____
2. Have you ever had any of the following:
   a) Tuberculosis, chronic bronchitis, emphysema or any other lung conditions? ☐ Yes ☐ No
      If so, do you require daily medication and/or oxygen? ☐ Yes ☐ No
   b) High blood pressure, heart problems, or rheumatic fever? ☐ Yes ☐ No
   c) Epilepsy or fits of any kind? ☐ Yes ☐ No
   d) Diabetes or cancer of any kind? ☐ Yes ☐ No
   e) Gout, arthritis, back, leg or foot problems? ☐ Yes ☐ No
      If Yes, please specify: _____
   f) Medically diagnosed depression, anxiety or psychiatric disorder? ☐ Yes ☐ No
      If Yes, please specify: _____
   g) Kidney or bladder disease? ☐ Yes ☐ No
      If Yes, please specify: _____
   h) Gastric or duodenal ulcer, colitis or intestinal trouble? ☐ Yes ☐ No
      If yes, please specify: _____
3. Do you have any physical limitations, handicaps or prosthesis? Do you have difficulty walking or use a device for mobility assistance such as crutches, a cane or wheelchair? ☐ Yes ☐ No
   If Yes, please specify: _____
4. Do you take medication or drugs related to a pre-existing medical condition? ☐ Yes ☐ No
   If Yes, please specify: _____
5. Do you have any allergies to any medication or drugs? ☐ Yes ☐ No
   If Yes, please specify: _____
6. Are you pregnant? ☐ Yes ☐ No
   If "Yes", how many weeks pregnant will you be at the time of travel?_____
7. Are you affected by any pre-existing medical condition above? ☐ Yes ☐ No
   If "Yes" please specify:

Please note:
*If you indicated "Yes" to any of the above questions (excluding question 5), you must proceed to section III.

SECTION III – MEDICAL PRACTITIONER FORM

If you indicated 'Yes' to any question in section 'II' (with the exception of question 5), kindly complete this section. Part 1 must be completed by yourself, and Part 2 must be completed by your medical practitioner. Once this form is completed and signed by both you and your medical practitioner, please return it to us electronically at documents@livethedashtours.com.

Become familiar with the details of your trip, the physical demands, the location of the tour, and access to medical facilities should they be required.

Part 1 – to be completed by you

Your Name _____

Booking Number _____

Name of trip _____

All information that is provided on this form will be kept by the Live The Dash Tours in accordance of our Privacy Policy, and your information will only be shared with those who are required to know in order to ensure a safe and enjoyable tour.

Part 2 – to be completed by your medical practitioner

Name of medical practitioner _____
Phone Number _____
E-mail _____

Office Address _____

Please list any current medical conditions, infirmities, disabilities or physical limitation.

_____

_____

_____

Please list all medication currently being taken. If more room is required, please attach a separate list

_____

_____

_____

Is this patient fit to travel unaccompanied?
☐ Yes ☐ No

If no, would they require a doctor, nurse or other health professional to accompany them?

_____

_____

If this patient has been hospitalized, or had surgery, at any time during the last 5 years, please tell us when and why

_____

_____

_____

Please list any other medical information:

_____

_____

_____

Prognosis for this trip: ☐ Good ☐ Poor

I have read the details of the trip and I am familiar with the physical demands, the remoteness of the location(s) of this trip, and the fact that this tour may be distant from medical facilities. Having taken all of this into account, I consider my patient to be physically and psychologically able/unable to travel.

I further declare the answers provided above to be accurate, complete and true.

Physician signature _____

Date _____

Patient

Date _____