PLEASE RETURN TO ACTION CHALLENGE ASAP EITHER BY POST, SCANNED E-MAIL or FAX

THIS MUST BE RECEIVED NO LATER THAN 10 WEEKS PRIOR TO DEPARTURE!

Please ensure you retain a photocopy for your own records

POST: Action Challenge UK Ltd, United House, North Road, London, N7 9DP | **E:MAIL**: events@actionchallenge.com | **FAX:** 0870 135 1256

MEDICAL DECLARATION FORM

NAME:	DOB:	TEL:
EMAIL:	TRIP - ROUTE / DATE :	

If you have a medical history, please ensure this form is filled out and signed and stamped by your GP. **If you do not have a medical history, you do not need to complete this form.** Please note this form will be passed on to the trip medic who may be in contact before departure. All information provided will be treated with the strictest confidence.

MEDICAL HISTORY: DO YOU SUFFER FROM OR HAVE YOU EVER SUFFERED FROM: (please circle)

Heart trouble and / or blood pressure problems?	YES / NO	Psychiatric or mental illness?	YES / NO
Asthma, bronchitis and / or shortness of breath?	YES / NO	Have you been hospitalised within the last two years?	YES / NO
Epilepsy and / or fainting attacks?	YES / NO	Are you suffering from or a carrier of any infectious disease?	YES / NO
Diabetes?	YES / NO	Are you registered disabled?	YES / NO
Severe head injuries?	YES / NO	Do you have any problems with sight, hearing or other?	YES / NO
Cancer?	YES / NO	Do you have any other on—going or past medical problems?	YES / NO
Allergies?	YES / NO	Are you pregnant or trying to get pregnant?	YES / NO
Fracture, tendon or ligament / cartilage damage?	YES / NO	Do you have a drug or alcohol dependency?	YES / NO

If you have answered YES to the question regarding asthma, please answer the following:

When was the last time you needed hospital treatment?	
When was the last time you needed steroid tablets?	
What medication / inhalers do you currently use?	

Please detail information on your medical history below. i.e. symptoms, occurrence, medication, dosage etc

PRINTED:		SIGNED:		DATE:	

IF YOU ARE OVER THE AGE OF 65 OR HAVE ANSWERED 'YES' TO ANY OF THE MEDICAL QUESTIONS, THE BELOW SECTION MUST BE COMPLETED BY A DOCTOR WHO HAS ACCESS TO YOUR MEDICAL HISTORY.

The above named person will be participating in a reasonably strenuous challenge, trekking or cycling for more than 5 hours a day for up to 7 days. Action Challenge UK Ltd. will provide a medical professional to give immediate first aid in the event of an accident, however the event may be a considerable distance from hospital. With the above information, if there is any matter of which you feel Action Challenge UK Ltd. should be aware of, please supply details on a separate sheet. If you need further information, please call us on +44 (0)20 7609 6695

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

PLEASE NOTE A DOCTOR'S SIGNATURE IS NOT VALID UNLESS SUPPORTED BY SURGERY STAMP

Print Name:	Date:
Doctor's Signature:	GMC no.
Address:	Surgery Stamp: **ESSENTIAL**