

First Name: _____ **Surname:** _____ **Birth date:** _____ **M or F**

Address: _____ **Postcode:** _____ **Ph:** _____

Medicare Number: _____ **Do you have Ambulance cover? Y or N**

Do you have private health cover? Y or N. If so, which Insurer? _____

Person to contact in an emergency: _____ **Relationship:** _____

Emergency Contact Numbers: (H) _____ (W) _____ Mobile: _____

Smoker Yes (), No (), Quit in last 5yrs (), **Weight** Normal (), 5-10kgs Over (), 10kg+ Over ()

Exercise per week prior to 2010 (continuous for 20 mins+) 3+ (), 2-3 (), 1-2 () None ()

Any injuries or limitations that might restrict strenuous bushwalking (eg back, leg, heart, recent illness etc.) If Yes, please explain? _____

Medical Information to be completed by Doctor

(this information will be kept strictly confidential)

Do you have, or have you had any of the following... (Please indicate with Y or N)

- | | |
|---------------------------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> Fainting spells or dizziness | <input type="checkbox"/> Diabetes (type 1 or 2?) |
| <input type="checkbox"/> Pre-existing heart conditions or angina | <input type="checkbox"/> Epilepsy (type & last episode) |
| <input type="checkbox"/> Heart stents, by-pass surgery | <input type="checkbox"/> Arthritis, rheumatism or chronic joint pain |
| <input type="checkbox"/> Stomach trouble requiring Doctor or ulcers | <input type="checkbox"/> Dislocation/s |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Knee, ankle or foot problems |
| <input type="checkbox"/> Concussion or head injury | <input type="checkbox"/> Anemia or Haemophilia |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Ear, nose or throat disorder |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Skin disease |
| <input type="checkbox"/> Asthma or other breathing disorder | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Chronic or frequent cough | <input type="checkbox"/> Phobias |

Special Dietary requirements _____ Any other conditions not listed _____

Do you have any allergies of any kind (eg; bee stings, pencillin, peanuts or other food intolerances)? YES / NO
If so, how severe is your allergy and what treatment do you normally require? **Note:** there are bees on the Kokoda Track

Have you had any recent surgery (including knee or joint operations)? YES / NO

Details: _____

Have you ever been advised to have surgery that has not been carried out? YES / NO

Details: _____

Are you currently taking any medication or do you need to carry preventative medication? YES / NO

If so what medication is required & please explain procedure for administration?

*Please ensure that your patient's heart and lungs are in good general health and that they have no existing musculo-skeletal problems that would prevent them from training for and completing the KokodaTrack.

Doctor's Clearance

In my opinion, there is no medical reason why _____ cannot participate in the Kokoda Trek. (including pre-trek bushwalks in the Adelaide Hills and trekking 96kms through steep jungle terrain)

Doctor's Signature: _____

Date: _____

Doctors Stamp
with name & phone number

*Please return to Wayne Enright – Free Spirit Adventures.

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