# GUEST MEDICAL PROFILE

It is very important for your own health and safety that you complete all questions fully and truthfully. In the event of a medical emergency, the information you have provided could be crucial. The more information Arctic Kingdom has, the more we may assist you in the unlikely event of an emergency.

Name:

MEDICAL INSURANCE
Insurance Company:

Phone Number:

Policy Name:

Policy Number:

Expiry:

EMERGENCY CONTACT
Name:

Phone Number:

FAMILY PHYSICIAN

Physician Name:

Clinic/Hospital:

Phone Number:

I have acquired **mandatory emergency evacuation coverage** (please attach proof of coverage):

◯YES ◯NO

QUESTIONNAIRE:
Please answer the following questions on your past and present medical history.

Have you ever had or do you currently have:

◯YES ◯NO Asthma, respiratory problems, or wheezing with breathing or exercise?
◯YES ◯NO If so, is the asthma well controlled with an inhaler?
◯YES ◯NO Gastrointestinal disturbances, including a colostomy or ileostomy?
◯YES ◯NO Diabetes?
◯YES ◯NO Is it controlled by diet?
◯YES ◯NO Is it controlled by medication?
◯YES ◯NO Bleeding, DVT (deep vein thrombosis) or blood disorders?
◯YES ◯NO Hepatitis or other liver disease?
◯YES ◯NO Neurological problems, epilepsy or seizures?
◯YES ◯NO Dizziness or fainting episodes?
◯YES ◯NO Migraines?
◯YES ◯NO Disorders of the urinary or reproductive tract?
◯YES ◯NO Cardiac problems, such as heart disease, angina, heart attack and stroke? Unexplained chest pain? Previous surgery?
◯YES ◯NO Family history or cardiac problems?
◯YES ◯NO High blood pressure?
◯YES ◯NO High cholesterol?
◯YES ◯NO Joint problems?
◯YES ◯NO Head injury with loss of consciousness in the past five years?
◯YES ◯NO Frequent colds, sinusitis or bronchitis?
◯YES ◯NO Any form of lung disease?
◯YES ◯NO Pneumothorax (collapsed lung)?
◯YES ◯NO Other chest disease or chest surgery?
◯YES ◯NO Behavioral health, mental or psychological issues (Panic attack, fear of closed or open spaces)?
◯YES ◯NO Frequent or severe suffering from motion sickness (seasick, carsick, etc.)?
◯YES ◯NO Any dive accidents or decompression sickness?
◯YES ◯NO Ear disease or surgery, hearing loss or problems with balance?
◯YES ◯NO Recurrent ear problems?
◯YES ◯NO Ulcers or ulcer surgery?
◯YES ◯NO Hernia?
◯YES ◯NO Sinus surgery?



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YES NO Recreational drug use or treatment for, or alcoholism in the past five years?
YES NO Could you be pregnant, or are you attempting to become pregnant?
YES NO Do you currently smoke a pipe, cigars or cigarettes?

What is your blood type? _____

During the last five years, have you suffered any significant illness, been hospitalized or required regular care by a doctor? If yes, please indicate the reason.

_____

_____

_____

Do you have any physical limitations, either from musculoskeletal injuries/fractures or other source, that affect your mobility or ability to take part in certain activities? For example, bad back, history of sprained ankles, knee surgery, etc. This is not intended to limit your activity, but to provide awareness to our staff. If yes, please provide details.

_____

_____

_____

Do you have any mental and/or physical disease, illness, disability or medical condition that affects your ability to take part in certain activities? This is not intended to limit your activity, but to provide awareness to our staff. If yes, please provide details.

_____

_____

_____

What medications are you currently taking?

| Medication | Dose | Side effects or restrictions | For what condition |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

If you require additional space or have any medical documentation you wish to include, please attach and submit.

☐ The information I have provided about my medical history is accurate to the best of my knowledge. I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health conditions.

Signature: _____ Date: _____

Parents and/or legal guardians must sign for participants under the age of 18.



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