Quark Expeditions® 3131Elliott Avenue, Suite 250 | Seattle, WA 98121 USA
+1.203.803.4441 *phone* | +1.203.547.6165 *fax* | +1.888.332.0008 *toll free in NA*
QuarkExpeditions.com

MEDICAL INFORMATION

EVERY MEMBER OF AN EXPEDITION MUST COMPLETE SECTION A AND B OF THIS FORM. SECTION C IS TO BE COMPLETED IF YOU CHECK AT LEAST ONE OF THE CATEGORIES LISTED IN SECTION A. THE COMPLETED FORM MUST BE SUBMITTED NO LATER THAN 90 DAYS PRIOR TO DEPARTURE.

PLEASE NOTE: OUR EXPEDITIONS ARE CONDUCTED IN ENGLISH, THEREFORE ALL FORMS AND DOCUMENTS ARE PROVIDED IN ENGLISH, AND MUST BE COMPLETED IN ENGLISH.

SECTION A: PERSONAL INFORMATION
(Every member of the expedition must complete this section)

Ship name ____ Expedition Dates ___________________________

Your name as it appears on your passport ____

Please indicate your age _________________________________

Medical Evacuation Insurance
Medical evacuation insurance coverage is mandatory for all passengers.

Insurance Policy Details

Name of insurance company ______________________________ Policy Number ____________________________

Insurer's emergency telephone number ____

Personal Emergency Information

Person to contact in case of an emergency ____
FIRST LAST

Relationship _____________________ Phone ________________________ Email______________________________

Dietary Restrictions

Please list any dietary restrictions

____

____

Date of your last full medical check-up ____

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Check all medical conditions for which you are currently under the care of a physician, or for which you have been under care in the past 6 months:

- ☐ Neurological – stroke, motor neuron diseases, multiple sclerosis, Parkinson's disease, polio, disorders of balance, seizures (epilepsy), dementia, memory disorders, intellectual impairment
- ☐ Musculoskeletal – joint replacements, muscle disorder (e.g. muscular dystrophy)
- ☐ Eyes – glaucoma
- ☐ Ambulation – use of a cane, walker
- ☐ Sensory – blindness, deafness, disorders of sensation (e.g. peripheral neuropathy)
- ☐ Physical – amputee, post trauma physical disabilities, post surgery physical disabilities
- ☐ Gastrointestinal – Crohn's disease, inflammatory bowel disease, ulcer
- ☐ Heart – bypass surgery, angioplasty, stent, high blood pressure, rhythm problems, pacemaker, heart failure
- ☐ Immune disorders – HIV, AIDS, steroid use
- ☐ Cancer – any type
- ☐ Lung – emphysema (COPD), asthma, ever been on a ventilator
- ☐ Mental Health disorders – depression, bipolar disease, mania, schizophrenia, psychosis
- ☐ Endocrine – diabetes, thyroid
- ☐ Blood thinner – anticoagulants (coumadin)
- ☐ Medications – any prescribed medications (exclude vitamins, supplements and laxatives)
- ☐ Pregnant at time of travel

Next:
IF YOU CHECKED AT LEAST ONE OF THE CATEGORIES IN SECTION A ABOVE, PLEASE COMPLETE SECTION C OF THIS DOCUMENT.

IF YOU CHECKED NOTHING IN SECTION A ABOVE, PLEASE COMPLETE SECTION B BELOW AND SIGN WHERE INDICATED.

SECTION B

I attest that I am in good health and mobility, and capable of performing normal activities on this expedition. I am able to climb steep stairs. I further attest that I am capable of caring for myself during the expedition, and that I will not impede the progress of the expedition or the enjoyment of others aboard. I understand that this expedition will take me far from the nearest medical facility and that all expedition members must be self sufficient. I am further aware that an emergency evacuation may be unavailable, expensive and delayed. I understand that the medical facilities and attention available

aboard the ship are limited to basic first aid care.

Signature of Traveler ________________________________ Date __________________________________

SECTION C

IF YOU CHECKED AT LEAST ONE OF THE MEDICAL CONDITIONS LISTED IN SECTION A, THEN IN SECTION C YOU MUST COMPLETE PART 1 AND YOUR PHYSICIAN MUST COMPLETE PART 2. EACH OF YOU MUST SIGN IN THE DESIGNATED SPACES AT THE END OF SECTION C.

Part 1

Your name ____
LAST FIRST MIDDLE

Name of ship ____

Please note that the ship's physician, Quark's medical director, insurance companies, evacuation companies and Quark personnel will have or may need access to your medical records.

Part 2

Name of physician ________________________________

Phone Number ________________ Fax Number ________________

Email ________________________________

Office Address ________________________________

City ________________ State ________________

Zip Code ________________ Country ________________

Please list any current medical conditions, infirmities or disabilities. If the patient is over 50 or has any heart disease, if possible, please give them a copy of their EKG.

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____
____

List all medicines currently taken by this patient. If more space is needed attach a separate sheet.

TRADE NAME	GENERIC NAME	DOSE/STRENGTH	FREQUENCY	PURPOSE

List any sensitivities or allergies to drugs:

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

What physical limitations does this patient have:

Please describe any walking aids used by this patient:

How many weeks pregnant will this patient be at the time of travel?

____

____

Signature of Physician ______________________________ Date ________________________________

Signature of Traveler ______________________________ Date ________________________________