BikeHike Adventures INC.
www.bikehike.com

# CONFIDENTIAL MEDICAL REPORT

Please complete both pages of this form and sign and return to the address below no later than 30 days before departure. If you are a doctor you cannot fill out this form on your own behalf.

TRIP NAME: DEPARTURE DATE : DAY / MONTH / YEAR

MR/MRS/MISS/MS: is booked with us to participate in a physical outdoor adventure. We ask all our participants who are **70 years or older** to have a sound medical checkup before the departure of the trip and ask for your kind co-operation in this matter.

We ask that you do a thorough medical examination of him/her, paying particular attention to the questions below, and making any suggestion that you think may be of use to him/her, us or to the leader of the tour. We respect the need for this information to remain confidential and know that you understand how vital it is that we only take people who are in good health on this type of adventure.

Please supply dates detailing history of any conditions your patient may have had or now has, frequency of problem, factors which generally bring on the problem, medication required, side effects or dietary requirements and resulting condition of patient.

DOES HE/SHE SUFFER FROM HIGH BLOOD PRESSURE? ☐ NO ☐ YES IF YES, PLEASE SPECIFY:

PLEASE SUPPLY DATES:

DOES HE/SHE HAVE A HEART CONDITION? ☐ NO ☐ YES IF YES, PLEASE SPECIFY:

PLEASE SUPPLY DATES:

DOES HE/SHE SUFFER FROM ANY BRONCHIAL DISORDER? ☐ NO ☐ YES IF YES, PLEASE SPECIFY:

PLEASE SUPPLY DATES:

IS HE/SHE AN ASTHMATIC? ☐ NO ☐ YES IF YES, PLEASE SPECIFY:

PLEASE SUPPLY DATES:

DOES HE/SHE HAVE SEIZURE DISORDER/EPILEPSY? ☐ NO ☐ YES IF YES, PLEASE SPECIFY:

PLEASE SUPPLY DATES:

PLEASE RETURN THIS FORM TO:
BikeHike Adventures Inc.
200-1807 Maritime Mews, Vancouver, BC V6H 3W7 Canada
Phone: 604-731-2442 | Fax: 604-677-5514 | Toll Free Phone: (888) 805-0061 | UK 0808.2341403 | Email: info@bikehike.com

HAS HE/SHE EVER SUFFERED ANY CHRONIC ILLNESS REQUIRING MEDICATION
(E.G. CANCER, HEART DISEASE, LUNG DISEASE, DIABETES, HIV, ETC.)? ☐ NO ☐ YES IF YES, PLEASE SPECIFY:

PLEASE SUPPLY DATES:

HAS HE/SHE HAD ANY MUSCULAR SKELETAL PROBLEMS
(I.E. JOINT, MUSCULAR, BACK, ANKLES, KNEES, ETC. IN THE PAST FIVE YEARS)? ☐ NO ☐ YES IF YES, PLEASE SPECIFY:

PLEASE SUPPLY DATES:

HAS HE/SHE HAD A SURGICAL OPERATION IN THE LAST FIVE YEARS
THAT WOULD AFFECT TRAINING/ACTIVITY LEVEL? ☐ NO ☐ YES IF YES, PLEASE SPECIFY:

PLEASE SUPPLY DATES:

ARE THERE ANY PROBLEMS THAT CONTINUE IN RELATION TO THE ABOVE TWO QUESTIONS? ☐ NO ☐ YES IF YES, PLEASE SPECIFY:

PLEASE SUPPLY DATES:

DO YOU FORESEE ANY PROBLEMS RELATED TO YOUR PATIENT'S PARTICIPATION
IN A BIKEHIKE ADVENTURE (I.E. PHYSICALLY DEMANDING ACTIVITIES
LIKE BIKING, HIKING, RAFTING, KAYAKING, HORSEBACK RIDING, RAPPELLING, ETC.)? ☐ NO ☐ YES IF YES, PLEASE SPECIFY:

PLEASE PROVIDE ANY GENERAL REMARKS, WHICH YOU CONSIDER TO BE IMPORTANT.

IS THE ABOVE NAMED PERSON FIT AND CAPABLE OF UNDERTAKING OUR ADVENTURE? ☐ NO ☐ YES

SIGNED: DATE:

TELEPHONE CONTACT OF DOCTOR:

Additional copies of all
BikeHike Adventures Inc.
forms are available at:
www.bikehike.com/reserve.html