MEDICAL ASSESSMENT

Complete form in BLOCK LETTERS

Participant Details:

First Name	Last Name	Date of Birth

Nationality	Male / Female	Wayoutback Tour Code & Booking No.

Assessment:

Please tick the appropriate box applicable to the applicant aforementioned:

(The certifying medical practitioner should consider the possible stress of travel on the individual)

TOUR REQUIREMENT	YES	NO	N/A	COMMENTS
Self-sufficient in regards to activities of daily living				
Tolerate humidity and heat in excess of 40 degrees during summer months				
Endure long days of up to 17 hours over a maximum period of 5 days				
Travel long distances away from any medical assistance				
If bringing Medical Equipment then they can operate this equipment unaided with minimal or no electricity supply eg Sleep Apnea Machines				
Walk unassisted / unaided over rocky and uneven terrain for a distance of up to 6 km's (tracks not suitable if any aides such as walking sticks or frames)				
Walk at a reasonable pace over long distances				
Pregnant, please advise: - Term - Single/multiple pregnancy - Absence of complications				
Tolerate long distance vehicle travel over uneven/rough terrain				
Can adequately self-administer any medication required				
Camp outdoors with minimal supply of electricity and running water				
Anything that will inhibit any of the activities which are contained in the attached itinerary				

Please attach any additional information which may be imperative to travel

Doctors Declaration (to be completed by the treating Doctor)

I certify that the above named passenger has been assessed by me as fit to travel on the nominated tour (itinerary attached).

I (name of Doctor) _____ hereby declare that to the best of my knowledge, (name of passenger) _____ is fit to travel.

Doctors Signature	Date	Clearance Valid Until:	Qualifications / Provider No.
Phone Number (Business Hours)		Phone Number (After Hours)	