

CONFIDENTIAL MEDICAL FORM

DEAR PARTICIPANT: Our tours are "adventure" tours and it is important that only physically fit persons participate on our tours. In order for you to participate in our tour, we request that you ask your physician to fill out and sign this confidential medical statement. This completed form must be returned to us no earlier than 3 months and no later than 1 month of tour departure date. Please note that Arctic Dog Adventure Co. respects the confidentiality of your medical information. Arctic Dog Adventure Co. will keep this information confidential and will only use the information in this statement to confirm that you are able to participate on the tour. When completed, please email this form directly to Lisbet@arcticdogco.com

RELEASE OF INFORMATION:				
Print Full Name of Patient/Participant				
If a Minor, Print Full Name of Parent/Guardian				
I, the undersigned, authorize the release of information patient/Participant, to Arctic Dog Adventure Comminformation between the Participant's health care relates to the diagnosis/condition listed and the hearticipant is medically fit to participate in the Arctic Participant is medically fit to participate in the Arctic Partici	on listed below regarding the above-named apany. I further authorize the exchange of a provider and Arctic Dog Adventure Co. as it nealth care provider's opinion on whether the			
Patient Signature	Date			

DEAR PHYSICIAN: The person named above is booked on a dog sledding adventure tour with us that involves physically challenging activities, including those specified below. Your confirmation that the Participant is medically fit for travel and the specified activities is requested.

The descriptions below apply to the Participant's tour. Please read these carefully and evaluate if it is appropriate for your patient to participate in our tour. Their safety and comfort is our highest priority. Feel free to call, text or email us with any questions or clarifications. **Main Contact:** Lisbet Norris, Owner/Lead Guide: (907) 841-4694 or lisbet@arcticdogco.com.

Please check off the following if applicable to your patient:

\sqcup	The participant is able to lift 50 lbs.
	The participant is able to endure hard falls onto ice or hard packed snow (good
	bone density).
	The participant must be able to hold onto the sled handlebars while getting
	dragged if the sled tips over (think being dragged by a waterskiing rope)
	The participant is able to squat to go to the bathroom outside (this is crucial).
	The participant is able to balance on one foot for 10-20 seconds and can hop
	from one foot to the other (The patient will need to jump on and off sled runners,
	like jumping on and off a slow moving treadmill).
	The participant is able to climb stairs quickly and easily, in both directions.
	The participant is comfortable bending down, as if to tie shoes or pick small
	objects off the ground. This action is repeated dozens of times a day when
	working with the sled dogs – harnessing, checking feet, etc.
	The participant is able to quickly jump up from a prone position on the ground
	(i.e burpees).
	The participant is able to endure occasional periods of walking or hiking on
	uneven terrain for 6 to 8 hours.
	The participant is in good cardiovascular health and can easily run or jog for 30
	seconds to a minute at a time.
	The participant is able to comfortably hike 5-10 miles at a time.
	The participant is able to endure exposure to extreme temperatures well below
	zero degrees Fahrenheit (no prior frostbite injury or significant circulation issues)
	The participant is able to wrangle strong sled dogs (good grip, strong wrists and
	shoulders).
	The participant is of sound cognitive health and can clearly think, learn and
	remember new tasks and directions.

(print participant's name), will be participating in an adventure vacation with Arctic Dog Adventure Company that may involve the activities indicated above as well as other unforeseen conditior associated with travel to remote Interior and Arctic Alaska.					
+ Please list any current medical conditions, infirmities, disabilities or physical limitations:					
+ Please list all separate list:	medication current	tly taken. If more r	oom is required	, please attach a	
Trade name	Generic name	Dose/Strength	Frequency	<u>Purpose</u>	
•	has been hospitalizell us when and wh	_	ry, at any time d	uring the last 5	

+ Is there anything else in regards to this patie know about in order to best ensure their safety		that we need to			
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I,, (print physician's name), have examined or am familiar with the above named person's physical health and believe him/her to be medically fit for travel and activities of this nature.					
Signature of Examining Physician	Date				
Street Address of Physician's Office					
City	State	Zip			
Phone Number of Physician's Office:					