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.

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 relating to the medical information requested below, including any diagnosis/condition listed below regarding the above-named Patient/Participant, to Arctic Dog Adventure Company. I further authorize the exchange of information between the Participant’s health care provider and Arctic Dog Adventure Co. as it relates to the diagnosis/condition listed and the health care provider’s opinion on whether the Participant is medically fit to participate in the Arctic Dog Adventure Co. trip.

_____ _____

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:

- ☐ 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 conditions associated with travel to remote Interior and Arctic Alaska.

+ Please list any current medical conditions, infirmities, disabilities or physical limitations:

_____

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_____

_____

_____

+ Please list all medication currently taken. If more room is required, please attach a separate list:

Trade name	Generic name	Dose/Strength	Frequency	Purpose

+ If this patient has been hospitalized, or had surgery, at any time during the last 5 years, please tell us when and why:

_____

_____

_____

_____

_____

+ Is there anything else in regards to this patient's health and fitness that we need to know about in order to best ensure their safety while out on the trail:

_____

_____

_____

_____

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: _____