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Doctor's certificate - worldwide

Name of Participant: _____

To Whom It May Concern,

Our client is planning on travelling on an **adventure to** _____

They will be away from medical support during this time.

We would like to be sure that each of our clients is in adequate physical and medical condition for the expedition and that our expedition leader is fully alerted to any potential health problems. We would appreciate your evaluation of the following.

The information you provide will be treated as confidential and will be only made available to the expedition leader, operations staff and DCXP medical advisor. Files will be kept for 7 years and then destroyed.

For how long have you been treating our client:

Overall physical condition:

Ability to participate on the intended trip:

Any medical conditions you feel the expedition leader and/or medical advisor should be made aware of:

Is there any reason why this client should not attend this trip:



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In the unlikely event of a serious wilderness emergency the expedition leader may need to provide advanced first aid without immediate access to a Doctor or the ability to gain a comprehensive medical history. To the best of your knowledge is it ok for your patient to receive the following medication (if no please explain):

	OK to give (please circle)	SHOULD NOT be given and WHY (please circle)
Antibiotics	OK to give	NO
Acetazolamide (Diamox)	OK to give	NO
Aspirin	OK to give	NO
Anti-nausea agents (e.g. Metoclopramide)	OK to give	NO
Benzodiazepines	OK to give	NO
Dexamethasone	OK to give	NO
Nifedipine	OK to give	NO
Non-steroidal anti-inflammatory agents	OK to give	NO
Local anaesthetic	OK to give	NO
Paracetamol	OK to give	NO
Promethazine/ other antihistamines	OK to give	NO
Sulphur Drugs	OK to give	NO
Any Other medication	OK to give	NO
Known Allergies (including food and bites)	None	Yes - Details:

Sometimes our medical advisor needs to clarify issues relating to a client's medical history.

Can our medical advisor contact you to discuss these issues if needed? Yes/No

Thanks for your time

Katie Sarah

DCXP Mountain Journeys Pty Ltd

Doctors name: _____ Date: _____

Qualifications: _____

Signature: _____ Phone: _____

Contact details: _____