MANDATORY HEALTH DECLARATION

General insurance information

Medical evacuation, if available, is expensive; therefore, it is necessary for you to have a Travel Protection Plan/travel insurance that will reimburse you for this cost. If you have taken out a Travel Protection Plan/travel insurance, can you please provide the below details.

NAME OF THE COMPANY:	
COMPANY'S EMERGENCY NUMBER:	
POLICY NUMBER:	

In declining the purchase of a Travel Protection Plan/travel insurance, I will not hold Hurtigruten AS responsible for any additional expenses/losses incurred resulting from my cancellation of this trip, accident, sickness, medical evacuation, lost or damaged baggage, or any other contingency that would have been covered by the insurance protection recommended.

DATE: .....

SIGNATURE: .....

Part 1: Health Declaration

This part of the form must be completed in English or using international medical terms.
Please do not abbreviate any words.

I attest that I am in good general health, and capable of performing normal activities on this expedition. I further attest that I am capable of caring for myself during the expedition, and that I will not impede the progress of the expedition or the enjoyment of others aboard. I understand that this expedition will take me far from the nearest medical facility and that all travelers must be self-sufficient. With that understanding, I certify that I have not been recently treated for, nor am I am aware of, any physical or other condition or disability that would create a hazard to myself or other members of the expedition.

EXPEDITION:	
DEPARTURE DATE:	
NAME:	
DATE:	

SIGNATURE: .....

Part 2: Medical Information

DATE OF BIRTH (DD/MM/YYYY)	
BLOOD TYPE (IF KNOWN):	
HEIGHT:	
WEIGHT:	

EVALUATE YOUR GENERAL HEALTH (PLEASE CHECK THE APPROPRIATE BOX):							
POOR	☐	**FAIR**	☐	**GOOD**	☐	**EXCELLENT**	☐
EVALUATE YOUR PHYSICAL CONDITION/STAMINA (PLEASE CHECK THE APPROPRIATE BOX):							
POOR	☐	**FAIR**	☐	**GOOD**	☐	**EXCELLENT**	☐

HAVE YOU TAKEN OUT TRAVEL PROTECTION WITH SUFFICIENT COVERAGE FOR MEDICAL REPATRIATION FROM THE DESTINATION IN WHICH YOU ARE TRAVELING? PLEASE CHECK THE APPROPRIATE BOX.			
YES	☐	**NO**	☐
DO YOU REQUIRE OXYGEN THERAPY ON A REGULAR BASIS? PLEASE CHECK THE APPROPRIATE BOX.			
YES	☐	**NO**	☐
IF YOUR ANSWER IS YES, PLEASE DESCRIBE THE CONDITION:			
.....			
.....			

Do you have, or have you had in the past 5 years, any of the conditions listed below? Please check the appropriate box.

CONDITION	**YES**	**NO**
High blood pressure		
Cardiac/heart disease: Cardiac valvulopathy, Coronary acute syndrome, Cardiac tamponade or any other		
Heart surgery		
Pulmonary conditions: Asthma/bronchitis, COPD-chronic obstructive pulmonary disease, pulmonary thrombosis		
Blood disorder: hemorrhage (excessive bleeding), clots, anemia or any other		
Diabetes: Type 1 or Type 2		
Digestive disorder: stomach ache, stomach ulcers, heartburn, bleeding, constipation, diarrhea, or any other		
Skin problem: sores, blisters, skin rash, burns, eruptions, itchiness or any other		
Allergies: dust, latex or any other		
Infectious/ contagious diseases		
Severe headaches - migraines		
Ear/nose/throat problems: hearing loss, earache, sinusitis, nosebleeds, or any other		
Restricted mobility/difficulty walking, use crutches, a walking stick or wheelchair		
Amputation		
Do you have a prosthesis or joint replacement?		
Fractures/dislocations		
Stroke		
Eye/vision problems: pain, dryness, redness, glaucoma, blurred vision, double vision or any other		
Autoimmune disorders: Lupus, Psoriasis, Celiac Disease(sprue) or any other		

Are you currently pregnant?		
Thyroid problems such as hypothyroidism /hyperthyroidism or any other		
Psychiatric disorders such as depression, anxiety or any other		
Tumors benign/malign: breast, lungs, intestine or any other		
Urinary system: pain, infections, prostatic hyperplasia (in men), kidney stones, renal failure or any other		
Spinal column and back problems: muscle contracture, herniated disk, sciatic nerve compression, spinal stenosis, scoliosis or any other		
Neurological disorders such as loss of consciousness, loss of memory/ balance problems (Alzheimer/Parkinson), epilepsy/seizures, dizziness/fainting or any other		
Musculoskeletal system: pain in joints, muscle pain, weakness, osteopenia/osteoporosis, swollen ankles/knees or any other		

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE DESCRIBE BELOW:

.....

.....

.....

DO YOU HAVE ANY OTHER MEDICAL CONDITIONS NOT MENTIONED ABOVE? PLEASE DESCRIBE BELOW:

.....

.....

DO YOU HAVE ANY MEDICAL ILLNESSES, DISABILITIES OR INFIRMITIES THAT REQUIRE THE REGULAR CARE OF A DOCTOR?

.....

.....

LIST ALL MEDICATIONS THAT YOU ARE TAKING AT THIS TIME, THE DOSAGES AND THE CONDITION THAT IS BEING TREATED:

MEDICATION	DOSAGE	WHAT ARE YOU TAKING THIS MEDICATION FOR?

HAVE YOU BEEN HOSPITALIZED OR HAD SURGERY IN THE LAST FIVE YEARS? IF YES, WHEN AND WHAT KIND OF SURGERY?

.....

.....

DO YOU HAVE ANY DRUG ALLERGIES? IF YES, WHAT ARE THEY?

.....

.....

DO YOU HAVE ANY DIETARY RESTRICTIONS OR FOOD ALLERGIES? IF YES, WHAT ARE THEY?
.....
.....

DO YOU HAVE ANY OTHER PHYSICAL OR MENTAL LIMITATIONS, OR HANDICAPS NOT MENTIONED ABOVE?
.....
.....

DO YOU HAVE ANY MOBILITY ISSUES THAT WOULD PREVENT YOU FROM CLIMBING IN AND OUT OF A RUBBER INFLATABLE BOAT (RIB), I.E. "ZODIAC" OR A RIGID HULL LANDING CRAFT I.E. POLAR CIRCLE BOAT (PLEASE CHECK THE APPROPRIATE BOX)?							
YES	☐	NO	☐				
IF YOU REPLIED YES TO THE PREVIOUS QUESTION, PLEASE CHECK THE FOLLOWING:							
CANE	☐	WALKER	☐	WHEELCHAIR	☐	PROSTHETIC LIMB	☐

EMERGENCY CONTACTS	NAME	RELATIONSHIP	PHONE NUMBER
CONTACT 1:			
CONTACT 2:			

On studying the information, we reserve the right to contact your doctor about health issues that could affect the journey.
☐ Please check the box if you prefer to be contacted first before we contact your doctor.

☐ **I hereby authorize that Hurtigruten can use the information provided in this document for the purpose of which it is intended. Ref Article 7. Hurtigruten will delete/destroy the information on completion of the voyage or as soon as possible when the information is no longer needed for medical purposes.**

Part 3: Medical Doctor's Opinion

Please give this form along with your itinerary to your personal doctor. Please check our webpage for an updated list of destinations where a doctor's opinion is required.

Dear Doctor,

Our traveler is planning an expedition cruise to the areas where sophisticated medical facilities are unavailable. Each vessel carries a doctor and a small infirmary. While not strenuous, travelers who participate on excursions must negotiate a steep gangway, get in and out of landing boats with assistance and be capable of walking a short distance over uneven and slippery terrain ashore. The areas being travelled in are very remote and where medevacs are possible can take up to 2 days and in some cases (such as South Georgia) medevacs are impossible, as the area is out of the range of helicopters and/or landing strips.
References to our Expedition Voyages: we ask you to take a quick look at the following links, just to give you an idea what kind of journey this is:
https://www.youtube.com/watch?v=PSJMTtp_6kQ
https://www.youtube.com/watch?v=ADwZDRriSHs

According to our regulations, passengers in "poor" health condition are in high risk of complications during the trip and therefore they should not join the voyage. Master and Doctor will deny passengers to come onboard with a medical form incomplete and/or with an unstable physical health condition.
We would like to be sure that each of our passengers is in adequate medical condition for the voyage and that our shipboard doctor is fully alerted to any potential health problems.

WE WOULD APPRECIATE YOUR EVALUATION OF THE TRAVELERS' OVERALL PHYSICAL CONDITION (PLEASE CHECK THE APPROPRIATE BOX):							
POOR	☐	FAIR	☐	GOOD	☐	EXCELLENT	☐
THE TRAVELERS' ABILITY TO PARTICIPATE IN THIS EXPEDITION AND EXCURSIONS:							
POOR	☐	FAIR	☐	GOOD	☐	EXCELLENT	☐

PLEASE ELABORATE ON ANY MEDICAL CONDITIONS THAT YOU FEEL OUR SHIPBOARD DOCTOR SHOULD BE AWARE OF:
.....
.....
.....

Thank you for your help.

DOCTOR'S NAME (BLOCK LETTERS)*:			
CODE:		REGISTRY NUMBER:	
TELEPHONE*:		E-MAIL:	
CITY, STATE, COUNTRY*:			

DATE*: .....

DOCTOR'S SIGNATURE*: .....

The doctor is not responsible for any medical occurrences during the voyage. By signing the medical form, the doctor is merely complying with the requirement that guests are fit for travel on the above-noted date.
mandatory fields.

DOCTOR'S STAMP: