



**ADVENTURE
ALTERNATIVE**
expeditions · treks · safaris

Expedition: **Mount Everest Base Camp**

Date (refer to website) _____

Please circle any required additional trips: **Island Peak** **Kathmandu Spa Break**

Title: _____ Full Name: _____

DOB: _____ Age: _____ Occupation: _____ Vegetarian (Y/N): _____

Address for correspondence: _____

_____ Postcode: _____

Tel: Home _____ Work _____ Mobile _____

Email: _____

Next of Kin Dtls: _____
(Name and tel number)

Please give brief details of any qualifications, awards or travel experience, which you think may be relevant to your application for the expedition:

Remittance Details: A deposit of £250 or 350 euro is required with the booking form. All cheques need to be made out to 'Adventure Alternative Ltd'. Installments to be made as per the joining instructions and receipts. Booking terms and conditions are available on the website, by signing below you confirm that you have read and understood them.

Signature: _____ Date: _____

(Parent or guardian if applicant is under 18, please include name and relationship to applicant)

Please return to: Adventure Alternative, PO Box 14, Portstewart, N. Ireland, BT55 7WS

ADVENTURE ALTERNATIVE MEDICAL FORM – confidential

The following questions are designed to assist us in any medical situation involving you. For this reason we ask that you provide all relevant details at this time, on a separate sheet if necessary, and advise us of any changes in your health/fitness between now and the date of departure.

The information you provide on this questionnaire will be accessed only by the Expedition Leader and Administrator. Except as directed by your own Doctor, no medical condition or handicap will automatically prevent anyone joining an Adventure Alternative Expedition; however it is important in planning the requirements of the expedition that we know about any such conditions. Please be aware that a 'certificate of fitness' may be required from your doctor in some cases and you will be advised if this is necessary.

Your Name:

	Yes/No	Details
1) Do you suffer from any of the following ? Asthma/difficulty breathing Diabetes Epilepsy Back trouble Heart Condition Recurring earrache/toothache Fainting spells		
2) Do you take any drugs regularly ?		
3) Do you suffer from any condition that affects your ability to carry weights or your overall mobility ?		
4) Are you allergic to any medication ? Eg Aspirin, penicillin, zinc oxide plaster		
5) Any planned changes in your medical condition ? Eg operations, medications		
6) Are you allergic to any foods or anything else ? Eg peanuts, dairy products, dust		
7) Do you have any pre-existing conditions or operations? eg head injuries		

I declare that the information given is to the best of my knowledge correct and complete. If you are under 18 years of age, your parent or guardian must sign here:

Signed:

Date: