Velindre Cancer Centre & The Ultimate Travel Company **Participant Medical Information Form**

Please read the notes below carefully before you fill in this form

All potential participants on Velindre's Majorca Bike Ride are required to complete this medical form.

Dedicated personnel will look at the forms, and may forward details on to our doctor for advice. All information will be treated as strictly confidential.

We request medical information from you in an endeavour to minimise risks to all participants, and for that reason ask that you disclose all your medical history. Velindre Cancer Centre and The Ultimate Travel Company cannot accept any responsibility in the event that you do not fully disclose all relevant details.

We want as many people as possible to take part in, and enjoy Velindre's Majorca Bike Ride, however, we nevertheless reserve the right to reject your application to participate in this event if recommended to do so by our medical advisorThe Majorca Bike Ride is challenging and will require a good level of fitness, strength and endurance. You should check with your doctor to ensure that you are sufficiently fit and healthy to participate.

There will be trained medical personnel on hand who will be able to provide treatment for minor injuries, and first aid support in the event of a more serious injury or medical problem.

Should you require more medical attention than can safely be provided on site, the medical officer and staff team will arrange appropriate evacuation and transfer to the nearest, most appropriate, hospital or medical centre.

If you develop any new medical conditions or experience worsening of existing conditions after returning this form, you must inform Velindre Cancer Centre and Ultimate Travel.

PART ONE: to be completed by each participant

Title (Mr/Mrs/Miss/Ms/Dr) ..... Date of birth .....Age .....

First Names .....Surnames .....

Address .....

.....

.....

Tel (day) ..... Tel (eve).....

Mobile .....

E-mail .....

Weight (kg) ..... Height (metres) .....

Do you have a history of any of the following conditions?

(please tick relevant box)

1. **Raised blood pressure** YES NO

If yes, please list the dates and values of your last three blood pressure readings:

Date			
BP (mmHg)			

2. **Heart or circulatory failure** YES NO

Details .....

3. **Blood clots, in particular DVT (clot in leg) or PE (clot in lung)** YES NO

Details .....

4. **Chest or lung disease** YES NO

Details .....

5. **Asthma** YES NO

If yes, have you ever:

Had to be hospitalised YES NO If yes when .....

Had to take steroid tablets YES NO

6. **Epilepsy** YES NO

Details .....

7. **Diabetes** YES NO

If yes, do you have **type I** or **type II** diabetes .....

Please list the dates and values of your last three HbA1c readings:

Date			
HbA1c (%)			

8. **Digestive or bowel disorders** YES NO

Details .....

9. **Haematological or blood disorders** YES NO

Details .....

10. **Cerebral disease e.g. stroke, head injury, tumour** YES NO

Details .....

11. **Past injuries e.g. fractures, sprains** YES NO

Details .....

12. **Operations** YES NO

Details .....

13. **Mental health problems** YES NO

Details (including any admission dates, any sections, specific diagnosis) .....

.....

14. **Allergies** YES NO

Details .....

15. **Heat illness or cold injury** YES NO

Details .....

16. **Thyroid disease, or other endocrine disorder** YES NO

If yes, please give the date and values of your last thyroid function tests:

Date	TSH	T4

Please list any medications you are currently taking:

If you have any other medical condition not disclosed above, please give details here:

I certify that I have read and understand this medical form. The information I have given is correct. In the event of illness or an accident on the trip, I hereby give permission for the tour operator medical staff to initiate medical treatment, and to notify my next of kin in case of hospitalisation.

Signed …….. Date ……..

I hereby give permission for The Ultimate Travel Company's medical advisor to discuss medical conditions relevant to this challenge with either my GP or hospital specialist.

Signed …….. Date ……..

PART TWO – to be completed by the participants GP if aged over 60 years OR have answered 'yes' to any question on the medical form.

I have read this medical form. The information given by the participant is correct, and no significant medical history contained in the patient's medical records has been withheld.

GP signature …….. Date ……..

GP Practice stamp:

Tel: ……..

Fax: ……..

If you, or your GP, have any medical queries you would like to discuss with The Ultimate Travel Company Medical Advisor, please contact the office, and we will be happy to arrange this.

For office use only

Date received …….. Date sent to Ultimate Travel Company ……..

MAJORCA Bike Ride

For further details please contact:

Velindre Fundraising, Velindre Cancer Centre
Whitchurch, Cardiff CF14 2TL
T: 029 2031 6211
E: info@velindrefundraising.com
W: www.velindrefundraising.com

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The Ultimate TRAVEL COMPANY

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Reg Charity No 1052501