For Ant NZ Use Only
Event Number K230
Estimated Deployment Dates
From ____ / ____ / ____ to ____ / ____ / ____

2014/15 MEDICAL EXAMINATION REPORT FORM

Please note this report form has **six** pages. **All** pages must be completed and returned along with the required test results. Incomplete forms or test results will penalise the candidate.

Surname (Print)			**First Names (Print)**
Address (Print)			
E-Mail Address (Print)			
Present Occupation			**Role in Antarctica**
Date of Birth (dd/mm/yy)	**Age**	**Sex** **Male / Female**	**Previous Antarctic Service** **Yes / No Year**

Antarctic Designation	**Medical Requirements**
Summer Base/Field	Medical Examination, ECG/Exercise stress test if over 60

DECLARATION - Applicant to read carefully before signing

- I understand that the information collected in this Medical Examination Form will be used for two primary purposes:
  1. To determine my fitness for travel and activity in Antarctica.
  2. To determine appropriate care should I require medical assistance while in Antarctica.
- I understand the information collected in this form will be held by Antarctica New Zealand's Medical Assessor and be accessible, if necessary to the First Aid Officer and Base Leader at Scott Base, and the General Manager Operations and Chief Executive in Christchurch, as per Antarctica New Zealand's medical policy.
- I understand that submission of the information requested is voluntary, but that failure to provide any of the requested details will disqualify my application to travel to Antarctica.
- If as a result of this examination, Antarctica New Zealand's Medical Assessor requires any further relevant details from my medical advisor, permission is hereby granted for that disclosure.
- I undertake to advise Antarctica NZ's Medical Assessor of any illnesses or injuries that may occur or be diagnosed subsequent to completion of this medical examination but prior to my deployment to Antarctica.

______________________ ______________________

Date *** Candidate's Signature**

______________________ ______________________

Date **Witness (Examining Doctor)**

* *Signature to be made in the presence of Examining Doctor*

MEDICAL IN CONFIDENCE

PART A – PERSONAL HISTORY QUESTIONNAIRE

To be completed before medical examination

NOTE: ALL QUESTIONS MUST BE ANSWERED

	DO YOU HAVE, OR HAVE YOU HAD?	YES	NO	EXAMINING DOCTORS COMMENTS *Required on any affirmative answers*
1	Rheumatic Fever	❒	❒	
2	Swollen or painful joints	❒	❒	
3	Chest pains or discomfort	❒	❒	
4	Abnormal shortness of breath	❒	❒	
5	High blood pressure	❒	❒	
6	Heart trouble	❒	❒	
7	Cholesterol disorders	❒	❒	
8	Bronchitis, Pleurisy or Pneumonia	❒	❒	
9	Coughing up of blood	❒	❒	
10	Tuberculosis	❒	❒	
11	Asthma	❒	❒	
12	Blood clots	❒	❒	
13	Hay-fever or allergy	❒	❒	
14	Nose, sinus, or throat trouble	❒	❒	
15	Discharging ears	❒	❒	
16	Deafness or defective hearing	❒	❒	
17	Eye trouble – worn glasses or contact lenses	❒	❒	
18	Fainting attacks, blackouts	❒	❒	
19	Fits - epilepsy	❒	❒	
20	Severe headaches, migraine	❒	❒	
21	Episodes of depression	❒	❒	
22	Mental illness, nervous breakdown	❒	❒	
23	Kidney or bladder trouble	❒	❒	
24	Recurrent indigestion - ulcer	❒	❒	
25	Vomiting or passing of blood	❒	❒	
26	Recurrent diarrhoea, dysentery	❒	❒	
27	Diabetes	❒	❒	
28	Thyroid disease	❒	❒	
29	Blood disease	❒	❒	
30	Jaundice or liver complaint	❒	❒	
31	Malaria or any tropical disease	❒	❒	
32	Hernia, rupture	❒	❒	
33	Sexually transmitted disease	❒	❒	
34	Head injury, concussion, unconsciousness	❒	❒	
35	Any joint injury or disease	❒	❒	
36	Backache, spinal injury, disc trouble, sciatica	❒	❒	
37	Any broken bones	❒	❒	

MEDICAL IN CONFIDENCE

PART A – PERSONAL HISTORY QUESTIONNAIRE

NOTE: ALL QUESTIONS MUST BE ANSWERED

DO YOU HAVE, OR HAVE YOU HAD?

#	Question	YES	NO
38	Recent loss of weight	❒	❒
39	Any skin complaint, eczema	❒	❒
40	Varicose veins	❒	❒
41	Severe reaction to a medicine	❒	❒
42	Have you previously been employed in a cold weather environment (if so, where)	❒	❒
43	Do you suffer from any cold weather complaints (chilblains etc)	❒	❒
44	Any illness not already stated	❒	❒
45	Do you smoke or have you been a smoker	❒	❒
46	Have you ever been rejected or discharged from military or civilian employment on medical grounds	❒	❒
47	Have you any illness or disability at present	❒	❒
48	Have you consulted a doctor in the past 12 months	❒	❒
49	Are you receiving any medical treatment at present	❒	❒
50	Are you taking **any** pills, tablets or medication now (Dr or Chemist).	❒	❒
51	Have you ever had any illness lasting more than 2 months	❒	❒
52	Have you ever lost more than a fortnight off work	❒	❒
53	Have you ever had any operations	❒	❒
54	Have you ever had any treatment for mental illness	❒	❒
55	Have you ever had an alcohol or drug problem	❒	❒
56	Have you ever been rejected, deferred or premium-loaded for Life Assurance	❒	❒
57	Have you ever received, applied for, or will apply for a pension or compensation for an existing or prior disability	❒	❒
58	Date of last period ...../........./.....		
	Any period or gynaecological trouble?	❒	❒

EXAMINING DOCTORS COMMENTS

Required on any affirmative answers

Q 50: List all medications currently taken (including over-the-counter medications and vitamins) by name, dose, how often taken and reason for taking.

MEDICAL IN CONFIDENCE

PART B – MEDICAL EXAMINATION

NOTE: ALL QUESTIONS MUST BE ANSWERED

No.	Item			EXAMINING DOCTORS COMMENTS *Required on any affirmative answers*
1	Physique:	**Excellent/ Average/ Poor**		
2	Height	----------------------	**cms**	
3	Weight	----------------------	**kgs**	
4	BMI - Body Mass Index (NB: applicants with a BMI over 35 will be declined)	--		
5	Identifying marks or features:	--		
		Normal	**Abnormal**	
6	Nose, sinuses	❒	❒	
7	Head, face, neck, scalp	❒	❒	
8	Mouth, throat	❒	❒	
9	Teeth, gums	❒	❒	
10	Ears			
	• General	❒	❒	
	• Tympanic membranes	❒	❒	
11	Eyes, general	❒	❒	
12	Eyes, movement	❒	❒	
13	Heart, size	❒	❒	
14	Heart, sounds	❒	❒	
15	Heart, rhythm	❒	❒	
16	Vascular system	❒	❒	
17	Chest, lungs	❒	❒	
18	Peak flow meter reading	❒	❒	
19	Abdomen	❒	❒	
	• Liver/spleen/kidneys	❒	❒	
20	Endocrine system	❒	❒	
21	Skin	❒	❒	
22	Lymphatic system	❒	❒	
23	CNS Reflexes	❒	❒	
24	Posture	❒	❒	
25	Fingers	❒	❒	
26	Hands	❒	❒	
27	Wrists	❒	❒	
28	Elbows	❒	❒	
29	Shoulder girdles	❒	❒	
30	Cervical, dorsal vertebrae	❒	❒	
31	Lumbar, sacral vertebrae	❒	❒	
32	Gait	❒	❒	
33	Pilonidal area	❒	❒	
34	Hip, knee, ankle, joints	❒	❒	
35	Speech	❒	❒	
36	Mental capacity	❒	❒	
37	Emotional stability	❒	❒	
38	Tremors	❒	❒	
39	Any evidence of:	**No**	**Yes**	
	• Herniae	❒	❒	
	• Hydrocoele	❒	❒	
	• Varicocoele	❒	❒	

MEDICAL IN CONFIDENCE

PART B – MEDICAL EXAMINATION

NOTE: ALL QUESTIONS MUST BE ANSWERED

		No	**Yes**
	Any evidence of:		
	• Toes, Hallux Rigidus, Valgus	❒	❒
	• Haemorrhoids	❒	❒
	• Varicose veins	❒	❒
40	Inoculations (date of previous immunisation, booster required if this is more than 20 years)		
	Polio Date:	....	
	Tetanus Date:	....	
41	Blood pressure – lying down		
	First reading	....	
	10mins later (if required)	....	
	10mins later (if required)	....	
	Heart Rate:	....	
42	Vision:		
	Unaided	R6	L6
	Corrected	R6	L6
43	Type of aid:	Glasses / Contact Lenses	
44	Colour Perception	**Normal**	**Abnormal**
	• Ishihara	❒	❒
45	Hearing:		
	• Right	❒	❒
	• Left	❒	❒

LABORATORY EXAMINATIONS

46 Blood group ABO, RH and blood group antibody screen

47 Complete blood count

48 RPR or VDRL

49 Hepatitis B antigen

50 Hepatitis C antibodies

51 HIV antibodies

52 Urinalysis (Dip Stick or MSU)

53 TB test (Quantiferon Gold or equivalent)
Or completed declaration form for recent returnees.

54 ✗ECG: Exercise stress test
- Date:
- Results: Normal / Abnormal

55 ✗Chest X-Ray
- Date:
- Results: Normal / Abnormal

EXAMINING DOCTORS COMMENTS

Required on any affirmative answers

Q46: Blood Group - No need to repeat if already known but copy of historical record is to be attached.

ALL TRACINGS AND REPORTS ARE TO BE ATTACHED TO THIS MEDICAL EXAMINATION FORM. (use the page overleaf)

Q52: Urinalysis – Dip Stick Results

Glucose	
Leucocytes	
Protein	
Blood	

✗ Required only from personnel as indicated in the “Guidelines”

TRACINGS AND REPORTS

PART C – ASSESSMENT
EXAMINING DOCTORS REPORT

I have thoroughly examined this candidate for travel to Antarctica and the appropriate diagnostic reports/ tracings accompany this completed form, as directed by the "Medical Guidelines".

I REGARD .... **FIT/ UNFIT**
(Candidate's Name)

FOR TRAVEL TO ANTARCTICA **DATE:** ....

NAME OR STAMP: ....
(Please print clearly)

SIGNATURE: ....

CONTACT DETAILS:

PHONE: .... **FAX:** ....

E-MAIL: ....

REASONS FOR REJECTION OR OTHER RESERVATIONS FROM EXAMINING DOCTOR SHOULD BE RECORDED HERE:

On completion of the Medical Examination, please send form and test results together to:

Postal;
Medical Assessor
Antarctica New Zealand
Private Bag 4745
Christchurch 8140
NEW ZEALAND

Courier;
Medical Assessor
Antarctica New Zealand
38 Orchard Road
Harewood
Christchurch 8053
NEW ZEALAND

COMMENTS OF ANTARCTICA NEW ZEALAND MEDICAL ASSESSOR:

Signature of Final Approval by Medical Assessor: ....

Date: ....