REQUIRED HEALTH STATEMENT
Expedition Cruising

Dear guests:

As the date of your expedition approaches it is important to understand that there are no sophisticated medical facilities available in these areas. Although the ship’s staff includes a qualified physician and nurse, and our onboard infirmary has basic medications and equipment, this expedition is intended for people in good health.

A Medical Declaration Form needs to be submitted by each passenger joining our voyages to the Antarctic Peninsula, South Georgia, the North East side of Greenland, and on the transatlantic voyages (all voyages via the Atlantic Ocean), due to the remoteness of these areas. Guests who may experience difficulties for any reason, including a disability, heart/pulmonary condition, or other health conditions, are asked to consult with their personal physician about the advisability of joining this expedition. To do otherwise would entail unreasonable risk to your health and to the enjoyment of all guests aboard.

If you are taking medications regularly, you are advised to carry a full supply with you as these may not be available on board or in the countries visited. In addition, it is strongly suggested to purchase medical insurance that covers you during your travels. In the event of a medical emergency, an evacuation, if necessary and if available, is extremely expensive. You must therefore carry sufficient insurance that will cover medical expenses and repatriation.

Please complete the attached forms. The Medical Declaration Form is to be completed and approved by your personal physician (medical doctor only) no more than 8 weeks before your departure date. The completed forms must be presented to the ship’s doctor upon boarding. Boarding will be denied if part III of the Medical Declaration Form is not approved by your personal physician. Even if the forms have been duly submitted and approved by your personal physician, the ship’s doctor and the captain reserve the right to deny the boarding of guests who do not seem to be sufficiently fit for travel.

Please note that all information contained in the Medical Declaration Form is intended as a medical reference for the onboard doctor and will be retained by him/her throughout the duration of the voyage.

Thank you for your cooperation.
GENERAL TRAVEL INSURANCE INFORMATION

Expedition Cruising

Each traveler must complete every section of this form.

Please bring this completed form with you when you board the ship. Medical evacuation, if available, is expensive. It is strongly suggested to have a Travel Protection Plan/travel insurance that will reimburse you for this cost.

If you have a Travel Protection Plan/travel insurance, please provide the below details.

Name of 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 offered.

Date, Signature: 

HURTIGRUTEN
MEDICAL DECLARATION FORM

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

PART I: TRAVELER’S HEALTH STATEMENT

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 aware of, any physical or other condition or disability that would create a hazard to myself or other members of the expedition.

Name: _____________________________________________________________

Date: __________________________________________________________________

Signature: ________________________

Voyage name: ________________________

Departure date: __________________________________________________________________

PART II: TRAVELER’S MEDICAL INFORMATION

Date of Birth: Day: ________ Month: ________ Year: ________

Blood type (if known): ________________________________________________

Height: _______________ Weight: ________________________________

Evaluate your general health: Poor □ Fair □ Good □ Excellent □

Evaluate your physical condition/stamina: Poor □ Fair □ Good □ Excellent □

Have you taken out medical insurance with unlimited medical reparation? Yes □ No □

Do you require oxygen therapy on a regular basis? 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?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>High blood pressure</td>
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<td>Cardiac/heart disease: Cardiac valvulopathy, coronary acute syndrome, cardiac tamponade, or any other heart condition</td>
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<td>Heart surgery</td>
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<tr>
<td>Pulmonary condition: Asthma/bronchitis, COPD (chronic obstructive pulmonary disease), pulmonary thrombosis</td>
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<td>Blood disorder: Hemorrhage (excessive bleeding), clots, anemia, or any other blood disorder</td>
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<td>Diabetes: Type 1 or Type 2</td>
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<td>Digestive disorder: Stomachache, stomach ulcers, heartburn, bleeding, constipation, diarrhea, or any other digestive disorder</td>
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<td>Skin condition: Sores, blisters, skin rash, burns, eruptions, itchiness, or any other skin condition</td>
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<td>Allergies: Dust, latex, or any other allergy</td>
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<td>Infectious/contagious disease</td>
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<td>Severe headaches/migraines</td>
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<tr>
<td>Ear/nose/throat condition: Hearing loss, earache, sinusitis, nosebleeds, or any other ear/nose/throat condition</td>
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<td>Restricted mobility/difficulty walking: Use of crutches, a cane, or a wheelchair</td>
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<td>Spinal column or back condition: Muscle contracture, herniated disk, sciatic nerve compression, spinal stenosis, scoliosis, or any other spinal column or back condition</td>
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<td>Amputation</td>
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<td>Prosthesis or joint replacement</td>
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<td>Fractures/dislocations</td>
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<td>Stroke</td>
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<td>Eye/vision condition: Pain, dryness, redness, glaucoma, blurred vision, double vision, or any other eye/vision condition</td>
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<td>Auto-immune disorder: lupus, psoriasis, celiac disease (sprue), or any other auto-immune disorder</td>
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<td>Are you currently pregnant?</td>
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<td>Thyroid condition: Hypothyroidism/hyperthyroidism or any other thyroid condition</td>
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<td>Psychological disorder: Depression, anxiety, or any other psychological disorder</td>
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<td>Neurological disorder: Loss of consciousness, loss of memory (Alzheimer’s), balance problems (Parkinson), epilepsy/seizures, dizziness/fainting, or any other neurological disorder</td>
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<td>Musculoskeletal system condition: Pain in joints, muscle pain, weakness, osteopenia/osteoporosis, swollen ankles/knees, or any other musculoskeletal system condition</td>
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<td>Tumors benign or malignant: Breast, lung, intestine, or any other tumors</td>
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<td>Urinary system condition: Pain, infections, prostatic hyperplasia (in men), kidney stones, renal failure, or any other urinary system condition</td>
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</table>
If you answered yes to any of the above, please describe below:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Do you have any other medical condition not mentioned above, please describe below:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Do you have any medical illnesses, disabilities, or infirmities/conditions 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.

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<tr>
<th>Medication</th>
<th>Dosage</th>
<th>What are you taking this medication for?</th>
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</table>
Have you been hospitalized or had surgery in the last five years? If so, when and what kind of surgery?

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Do you have any drug allergies? If so, what are they?

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Do you have any dietary restrictions or food allergies? If so, what are they?

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Do you have any other physical or mental limitations, or disabilities not mentioned above?

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Do you have any mobility issues that would prevent you from climbing in and out of a Rubber inflatable boat (RIB) such as a Zodiac, or a rigid-hull landing craft such as a Polarcirkel boat?  Yes ☐  No ☐

If you replied YES to the previous question, do you have/use any of the following:

Wheelchair ☐  Prosthetic limb ☐  Cane ☐  Walker ☐
Who should we contact in case of emergency?

**Contact 1:**

Name: ___________________________  Relationship: ___________________________

Phone Number (s): ___________________________

**Contact 2:**

Name: ___________________________  Relationship: ___________________________

Phone Number (s): ___________________________

*Upon reviewing this information, we reserve the right to contact your doctor about health issues that could affect the journey.*

☐ *Please check this box if you want to be contacted first before we contact your doctor.*


PART III: MEDICAL ADVISOR’S OPINION

Please give this form along with your itinerary to your personal physician.

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

Dear doctor,

Our traveler, your patient, is planning an expedition cruise to an area where sophisticated medical facilities are unavailable although each vessel has a physician and a small infirmary on board. While not strenuous, travelers who participate in 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/or slippery terrain ashore. The areas being traveled in are very remote. Where medical evacuations are possible, they can take up to two days to arrive, and in some cases (such as South Georgia) medical evacuations are not possible, as the area is out of the range of helicopters and/or landing strips.

Please see the attached itinerary and the links below, which may give you a better idea of our expedition cruises to remote areas.

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 at high risk of complications during the trip and therefore they should not join the voyage. The master and doctor will not allow any passengers on board that have an incomplete medical form and/or with an unstable 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 physician is fully alerted to any potential health problems.

Please evaluate the traveler’s overall physical condition:

Poor ☐       Fair ☐       Good ☐       Excellent ☐

Please evaluate the traveler’s ability to participate in this expedition and excursions:

Poor ☐       Fair ☐       Good ☐       Excellent ☐

Please elaborate on any medical conditions that you feel our shipboard physician should be aware of.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
Thank you for your help.

Doctor’s name: ________________________________
(Printed letters)

Date: ________________________________

Doctor’s signature: ________________________________

Code: __________________ Registry number: __________________

Telephone: __________________ Email: __________________

City, State, Country: ________________________________

Doctor’s Stamp: ___________________________