



MEDICAL STATEMENT

Participant Record (Confidential Information)

CLIMBING DESCRIPTION

Climbers must be aware of, and be able to understand the following details in order to consider their ability to participate in the climb :

1) Mt. Alab is considered moderately challenging.

2) Temperatures can vary from 13 to 23 degrees Celsius and can be much colder at night depending on the weather (windy or rainy, etc) condition.

3) Climbers will be ascending to a height of 2,050 meters above sea-level.

4) Climber's must be prepared to :

a) Trek in cold or hot and humid environment for up to 5hours or more.

b) Trek through wet conditions especially during or after a heavy downpour, expect slippery conditions.

c) Not have access to seating, water, shade or proper toilets during the trek.

d) Carry own packed lunch and own water during the climb as they are no sources of water on this mountain as well as extra sources of food such as nuts, energy bars, etc. (A porter can be hired at an additional cost)

5) Climbers must ensure that they are / will :

a) Medically fit or in good physical condition and are able to climb to an altitude of above 2,000 meters above sea-level. It is encouraged that all climbers have themselves medically checked before attempting the climb.

b) Fit to withstand mild to moderate adverse weather and elevation conditions associated with climbing at the height stipulated.

c) Not pregnant at the time of climb.

d) Adhere to the suggested packing / things-to-bring list provided.

e) Adhere to the instructions of the Park Ranger during the climb. Safety is always the priority and should they feel that it is not safe to continue the climb for any reason, their decision must be respected. Should this be the situation there will be no refund in part of in full for your climb.

6) Climbers are encouraged to :

a) Have themselves medically checked before attempting the climb.

b) Participate in physical or outdoor activities prior to climb. Here are some suggestions from the Alpine Guides Association :

b1) A good amount of outdoor cardiovascular exercise (power walking, cycling, running, mountain biking, etc) and getting out for long days in the hills whenever possible is great preparation for your climb.

b2) We recommend all climbers take cardiovascular sports at least twice a week, with each session being a minimum of 2 hours in duration at a medium intensity.

b3) Fitness training should begin 2-3 months leading up to your trip, this way you should be well prepared.



DOWNBELOW

MARINE & WILDLIFE ADVENTURES SDN. BHD

Please read carefully before signing.

This is a statement in which you are informed of some potential risks involved in mountain climbing. Your signature on this statement is required for you to participate in the climb offered by DOWNBELOW MARINE & WILDLIFE ADVENTURES SDN BHD and it's affiliates located at MT ALAB, TAMBUNAN in the state / province of SABAH, MALAYSIAN BORNEO.

Read this statement prior to signing it. You must complete this Medical Statement, which includes the medical questionnaire section, to enroll in the climb. If you are a minor, you must have this statement signed by a parent or guardian.

CLIMBERS MEDICAL QUESTIONNAIRE

To the Participant:

The purpose of this Medical Questionnaire is to find out if you should be examined by your Doctor before participating in any climbing program offered. A positive response to a question does not necessarily disqualify you from climbing. A positive response means that there is a preexisting condition that may affect your safety while climbing and you must seek the advise of your physician prior to engaging in the climb.

Please answer the following questions on your past or present medical history with a YES or NO. If you are not sure, answer YES. If any of these items apply to you, we must request that you consult with a physician prior to participating in the climb. You may take this form to your physician.

- ___ Could you be pregnant, or are you attempting to become pregnant ?
- ___ Are you presently taking prescription medications? (with the exception of birth control or anti-malarial)
- ___ Are you over 45 years of age and can answer YES to one or more of the following ?
 - currently smoke a pipe, cigars or cigarettes
 - have a high cholesterol level
 - have a family history of heart attack or stroke
 - are currently receiving medical care
 - high or low blood pressure
 - diabetes mellitus, even if controlled by diet alone

Have you ever had or do you currently have...

- ___ Asthma, or wheezing with breathing, or wheezing with exercise ?
- ___ Frequent or severe attacks of hayfever or allergy ?
- ___ Behavioral health, mental or psychological problems ?
- ___ Epilepsy, seizures, convulsions or take medications to prevent them ?
- ___ Recurring complicated migraine headaches or take medications to prevent them ?
- ___ Blackouts or fainting (full/partial loss of consciousness) ?
- ___ Dysentery or dehydration requiring medical intervention ?
- ___ Inability to perform moderate exercise (example: walk 1.6km/one mile within 12 minutes) ?
- ___ Head injury with loss of consciousness in the past five years ?
- ___ Diabetes, Hypertension, Palpitation ?
- ___ Heart Disease ?
- ___ Obesity ?
- ___ Hepatitis (jaundice) ?
- ___ Heart attack ?
- ___ Back, Arm or Leg problems following surgery, injury or fracture ?
- ___ Arthritis, Severe Anemia ?
- ___ Peptic Ulcers or Ulcer surgery ?
- ___ Muscular Cramps ?
- ___ Bleeding or other blood disorder ?
- ___ High or Low blood pressure ?
- ___ Problems with balance ?
- ___ Allergic to Bee Stings ? If yes, please confirm you will bring your Ephedrine & take responsibility to self administer.

The information I have provided about my medical history is accurate to the best of my knowledge. I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health condition.

Signature

Date

Signature or Parent or Guardian

Date



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DOWNBELOW

MARINE & WILDLIFE ADVENTURES SDN. BHD

CLIMBER

Please print legibly.

Full Name (as per passport) _____ Date of Birth _____

Mailing Address _____ City _____

State/Province/Region _____ Country _____ Zip/Postal Code _____

Home Phone () _____ Business Phone () _____

Email _____ Fax _____

Name and address of your family physician

Physician _____ Clinic/Hospital _____

Address _____

Date of last physical examination _____

Name of examiner _____ Clinic/Hospital _____

Address _____

Phone () _____ Email _____

PHYSICIAN

This person applying for MT ALAB Climbing Activity. Your opinion of the applicant's medical fitness for this climb is requested.

Physician's Impression

_____ I find no medical conditions that I consider incompatible with Climbing Activity.

_____ I am unable to recommend this individual for Climbing Activity.

Remarks

_____ Date _____

Physician's Signature or Legal Representative of Medical Practitioner

Physician _____ Clinic/Hospital _____

Address _____

Phone () _____ Email _____

