ADVANCED EXPLORATIONS INC.

Medical Questionnaire and Emergency Notification Form

Last Name: _____

First Name: _____

Sex: □ Male or □ Female Age: _____

Date of Birth (yyyy-mm-dd):_____

Health Card Number: _____

First Aid Course: Level: _____

Exp.:_____

Home phone: _____

Work Phone: _____

Home Address: _____

_____

City: _____ Province: _____

Postal Code: _____

E-mail:_____

Emergency Contact:

Name: _____

Relationship: _____

Daytime Phone: _____

Evening Phone: _____

Cell phone: _____

Address: _____

City: _____ Province: _____

Postal Code: _____

Are you currently under a doctor's care?	YES □	NO □
Are you currently on any medication?	YES □	NO □
Do you have any allergies? If yes, do you carry an Epi-pen? YES □ NO □	YES □	NO □
Do you have any dietary restrictions?	YES □	NO □
Do you suffer from a digestive or bowel disorder?	YES □	NO □
Have you experienced any joint or mobility problems in the last 12 months?	YES □	NO □
Have you had any surgical operations in the last 12 months?	YES □	NO □
Do you have high blood pressure?	YES □	NO □
Do you suffer from a bleeding disorder?	YES □	NO □
Do you suffer from a heart or circulatory disease?	YES □	NO □
Have you ever suffered a heart attack or angina attack?	YES □	NO □
Have you ever had a seizure, epilepsy, a stroke or a neurological problem?	YES □	NO □
Are you afflicted by mental/emotional instability or any mental health issues?	YES □	NO □
Do you have chest/lung disease?	YES □	NO □
Do you have Tuberculosis?	YES □	NO □
Do you have asthma?	YES □	NO □
Do you have diabetes?	YES □	NO □
Do you have any history of kidney or liver problems?	YES □	NO □
Have you ever been vaccinated for tetanus in the last 5 years?	YES □	NO □
Have you ever tested positive for Hep C?	YES □	NO □
Are you vaccinated against Rabies?	YES □	NO □
Are you pregnant or think you might be?	YES □	NO □
Do you suffer from motion sickness?	YES □	NO □
Do you smoke?	YES □	NO □

If you have answered YES to any of the above, please offer specifics below. If there is something the medical personnel should be made aware of, that was not included above – please specify below.

_____

_____

_____

_____

I certify that the above information is true to the best of my knowledge and that I am fit to work. I understand that while Advanced Explorations Inc. (AEI) and any contracted medical company will do their utmost to ensure I receive the best and most prompt medical care as possible in any emergency, my work site is located far from advanced medical care. I understand that the arrival of emergency aid and transportation to an advanced medical facility/hospital can take time, and can experience significant delays due to unforeseen situations including, but not limited to poor weather and mechanical failure. Information contained in this document is for the use of Advanced Explorations Inc. (AEI) and any contracted First Aid Company in the event of an emergency.

Name (please print):_____

Signature: _____

Date: _____

Witness Name (Please print):_____

Witness Signature: _____

Date: _____