



CONFIDENTIAL MEDICAL FORM COVER INFORMATION

The information you provide to All About Destinations in this form will be used only to the extent necessary to provide medical care. The collection, use, and disclosure of your personal information is governed by the All About Destinations privacy protocols

Why do I need to complete this form?

We travel to remote areas both domestically and abroad where limited medical facilities exist. Should a medical emergency arise we are armed with the necessary information to help you.

You must provide complete, accurate, and up-to-date information on this form in order to allow All About Destinations to safely accommodate you.

If you do not disclose a medical condition and are subsequently deemed to be unfit for travel due in whole or in part to such condition, All About Destinations shall have the right to remove you from your trip with no refund or compensation payable.

If there are any changes to your medical condition or otherwise to your responses below after submission of the form to All About Destinations, you must notify All About Destinations immediately of that change.

If you completed this form 12 months or more prior to your date of first travel, you must provide All About Destinations with current information prior to departure or confirm your information has not changed.

What happens if I do not complete this form?

In the event you have made a booking with All About Destinations and are unable or refuse to complete this medical form for any reason by the final payment date as specified in our terms and conditions, All About Destinations reserves the right to cancel your booking as of that day and applicable cancellation penalties will apply.

**** Please return this form by e-mail to: allaboutdestinationstravel@gmail.com**

WVU Alumni Band Members, just return the below forms to Jeff at the CAC, Dulles Airport or London



CONFIDENTIAL MEDICAL FORM

Please complete all three sections of this form.

SECTION I – GENERAL INFORMATION: Please complete all fields

Name: _____ Booking Reference: WVU3-2026
Trip Name: WVU Alumni Band European Tour 2026 Departure Date: July 7, 2026

SECTION II – MEDICAL INFORMATION: Please complete all fields

1. During the last year, have you suffered any significant illness, been hospitalized or required regular care by a doctor? Yes No

If YES, please indicate reason: _____

2. Have you ever had any of the following:

- a) Tuberculosis, chronic bronchitis, emphysema or any other lung problems? Yes No
- b) Asthma effects my everyday activities and/or I use medication or an inhaler regularly Yes No
- c) High blood pressure, heart or respiratory problems, or rheumatic fever? Yes No
- d) Gout or arthritis or any back, leg or foot problems? Yes No
- e) Gastric or duodenal ulcer, colitis or intestinal trouble? Yes No
- f) Epilepsy or fits of any kind? Yes No
- g) Kidney or bladder disease? Yes No
- h) Diabetes, cancer or tumour of any kind? Yes No

3. Do you have any physical limitations, handicaps or prosthesis? Do you have difficulty walking or use a device for mobility assistance such as crutches, cane or wheelchair? Yes No

If YES, please specify: _____

4. Do you take medication or drugs related to a pre-existing medical condition? Yes No

5. Do you have any allergies, or reactions to any medication or drugs? Yes No

If YES, please specify: _____

6. Are you pregnant? Yes No

If YES, how many weeks pregnant will you be at the time of travel? _____

7. Are you affected by any other pre-existing medical conditions not listed above? Yes No

If YES, please specify: _____

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SECTION III – MEDICAL PRACTITIONER/MEDICATION FORM: Please complete all fields

We travel to remote areas where limited, or no medical facilities exist. These trips are intended for travelers in reasonably good health without medical conditions that may require urgent medical attention of this level.

Passengers who are not fit for long trips or trips to remote areas for any reason, including mobility issues, heart or other health conditions are advised not to join the tour, which would entail an unreasonable risk to your health and to the enjoyment of all those aboard.

Physician's
Name: _____

Phone Number: _____ Email: _____

Office
Address: _____

Please list any current medical conditions, infirmities, disabilities or physical limitations:

Please list all medication currently taken. If more room is required, please attach a separate list.

<i>Trade name</i>	<i>Generic name</i>	<i>Dose/Strength</i>	<i>Frequency</i>	<i>Purpose</i>
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Date: _____ **Signature:** _____