

Dear Traveller, please take this form to your medical doctor and return it when you book your holiday. Please note: if you return this form after paying your deposit and your doctor subsequently deems you not fit to travel, in some cases we may not be able to refund your monies paid (in part or full). Before visiting your doctor we recommend you check with us about trip availability as a place can only be confirmed subject to availability and the deposit payment.

Dear Doctor

In the best interests of our clients we require that passengers of 70 years and over obtain medical clearance to ensure they are fit to travel on their chosen holiday. Suitability for this trip requires that the passengers have reasonable physical fitness, can travel independently and that they do not require special assistance. Please also take into account any forms of dementia, mental disorders or addictions that would limit their ability to travel.

Minimum Physical Requirements: Travellers must have a reasonable level of fitness and mobility, and meet the following minimum requirements:

- Walk up to 1km, and on uneven surfaces without a mobility aid, duress or needing to take a break? Yes ____ No ____
- Participate in a sightseeing tour on foot with a duration of up to 1-2 hours Yes ____ No ____
- Stand for extended periods without the need to sit? Yes ____ No ____
- Climb a flight of stairs without duress? Yes ____ No ____
- Carry luggage (up to 23kg) and hand luggage without assistance (up to 7kg)? Yes ____ No ____

Doctor's Opinion

If your patient cannot meet any/all of the above physical requirements please detail here what physical requirements they are capable of meeting. In some instances, even if a traveller does not meet the physical requirements as above, it may still be possible that they join the tour if they accept some excursions or activities may have to be forfeited.

Also detail any physical or mental health conditions, including medications, recent surgery, and if they use a CPAP machine:

Name of Doctor: _____

Doctor's Signature: _____

Address of Practice: _____

Telephone: _____

Date ____ / ____ / ____

Official Practice Stamp:

Passenger's Signature: _____

Date of Signature: ____ / ____ / ____

*Passenger Name: _____

*Holiday Name: _____

*Travel Dates: _____