



**SHERPA KHANGRI OUTDOOR**  
夏尔巴高山探险

## Medical Examination

Participants on SKO expeditions are required to have a medical provider fill out this form. This examination must be completed within 1 YEAR of the expedition start date.

### INFORMATION FOR THE MEDICAL EXAMINER

Sherpa Khangri Outdoor (SKO) leads expeditions, which vary in length from 14 to 60 days. These programs are located in remote areas where air evacuation to modern medical facilities can take many days when the weather is poor. Weather conditions can be extreme with temperatures ranging from  $-40^{\circ}\text{F}$  to  $+100^{\circ}\text{F}$  and winds up to and above 100 mph. prolonged storms, high winds, intense sunlight, and sudden immersion in cold water are possible. The environment includes large crevassed glaciers, loose rock, talus slopes, tundra, and forest and river crossings. Depending on the type of expedition, the applicant will be wearing crampons on exposed and uneven snow slopes. The applicant will be living and sleeping outdoors in tents and will undertake long and strenuous days. Each participant is expected to be able to take care of him or herself.

### NOTE TO MEDICAL EXAMINER & EXPEDITION PARTICIPANT:

If the SKO participant is scheduled for a high altitude expedition and is allergic to sulfa drugs, it is highly recommended to administer a trial dosage of Diamox before the expedition while under the supervision of a physician. The individual wishes to join a program with the following physical demands:

1. The Participant, \_\_\_\_\_, age \_\_\_\_\_, has been examined on \_\_\_\_\_ (\_\_\_\_/\_\_\_\_/\_\_\_\_)

2. Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respiratory Rate: \_\_\_\_\_

3. Physical Appearance & Mental State: \_\_\_\_\_

4. On the basis of the information on this form, your history with the individual, and your current examination, can this person participate in the selected program?  Yes  No

5. General impressions and comments: \_\_\_\_\_



**EXAMINER'S NAME & ADDRESS:**

Title: \_\_\_\_\_

Hospital: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Examiner's Signature: \_\_\_\_\_

Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_



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