



**NOTE: Red boxes indicate required fields.
The forms will not be accepted if these fields are blank.**

PIPELINE # _____

PARTICIPANT
NAME: _____

MEDICAL HISTORY

The PARTICIPANT COMPLETES this Medical History form prior to any exam.

Polar Medical Staff Use Only	Date: _____	<input type="checkbox"/> Summer PQ	<input type="checkbox"/> Winter PQ	<input type="checkbox"/> NPQ
	Medical Condition(s): _____			
	Reviewed by: _____			
	Date: _____	Restrictions and Follow-up: _____ _____		
		Reason for NPQ: _____		

CONTACT INFORMATION (INCLUDE AREA CODES):			
Name last, first, middle (must match official ID): _____	Age: _____	Birthdate: (MM/DD/YYYY) _____	Sex Assigned at Birth, on original birth certificate: <input type="checkbox"/> F <input type="checkbox"/> M
Nickname: _____	Maiden Name: _____	Previous Name or Other Legal Name: _____	
Street Address: _____		E-Mail: _____	
City: _____	State: _____	Zip: _____	Country: _____
Day Telephone: _____	Evening Telephone: _____	Mobile: _____	Fax: _____

EMERGENCY POINT OF CONTACT:	
Name: _____	Address: _____
Phone Number: _____	

DEPLOYMENT INFORMATION			
Job Title: _____	Estimated Deployment Dates: (MM/YYYY) From: _____ To: _____	Prior Polar Deployment (Arctic or Antarctic)? (MM/YYYY) Location: _____ From: _____ To: _____	
Affiliation: <input type="checkbox"/> NSF <input type="checkbox"/> Science _____ <input type="checkbox"/> Technical Event _____ <input type="checkbox"/> Event Company Name _____ <input type="checkbox"/> Other _____			

Proposed Antarctic Season	Worksite	Dates	<input type="checkbox"/> Field Camp :
<input type="checkbox"/> Summer (Sep-Feb)	<input type="checkbox"/> McMurdo Station	_____	
<input type="checkbox"/> Summer Extended (WINFLY and/or Mar, May)	<input type="checkbox"/> South Pole Station	_____	<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Winter (Mar-Oct)	<input type="checkbox"/> Palmer Station	_____	
<input type="checkbox"/>	<input type="checkbox"/> Vessel	_____	<input checked="" type="checkbox"/> Two Year PQ
	<input type="checkbox"/> Traverse	_____	
(dates)			

Proposed Arctic Season	Worksite	Dates	<input type="checkbox"/> Field Camp:
<input type="checkbox"/> Summer (Mar-Sep)	<input type="checkbox"/> Summit	_____	<input checked="" type="checkbox"/> Two Year PQ
<input type="checkbox"/> Winter (Oct-Feb)	<input type="checkbox"/> Raven	_____	



MEDICAL HISTORY FORM

PIPELINE # _____

PARTICIPANT
NAME: _____

MEDICAL HISTORY					
CURRENT MEDICATIONS - (Check box if None) <input type="checkbox"/>					
Name	Dose	Frequency	Name	Dose	Frequency
DRUG ALLERGIES - (Check box if None) <input type="checkbox"/>			FOOD ALLERGIES - (Check box if None) <input type="checkbox"/>		
Name	Type of Reaction		Name	Type of Reaction	
PAST HOSPITALIZATIONS - (Check box if None) <input type="checkbox"/>					
Condition		Date (YYYY)	Condition		Date (YYYY)
PAST SURGERIES - (Check box if None) <input type="checkbox"/>					
Condition		Date (YYYY)	Condition		Date (YYYY)
MEDICAL TESTING / PROCEDURES IN PREVIOUS 3 YEARS - (Check box if None) <input type="checkbox"/>					
Type (specify body location)		Date (YYYY)	Describe reason for test procedure and result:		
MRI					
CT					
Ultrasound					
Angiogram					
Biopsy					
Catheterization (Cardiac, Renal, etc)					
Other:					
VACCINATION HISTORY					
Most recent vaccination Date		(YYYY)	Most recent vaccination Date		(YYYY)
COVID-19(Current Deployment Season)			Other		
Influenza (Current Deployment Season)			Bacillus - Calmette (BCG) Vaccine (Given in childhood in countries with high rates of TB)		Yes <input type="checkbox"/> No <input type="checkbox"/>
DT/Tdap					
MMR					
Hepatitis A					
Hepatitis B					
Additional Space (Please attach proof of vaccination for required vaccinations as noted on "Dear Doctor" section):					

LIFESTYLE



MEDICAL HISTORY FORM

PIPELINE #

PARTICIPANT
NAME:

Tobacco	Yes	No	Describe: Packs/Day	Total yrs.	Year last
Do you currently use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>			
Have you used tobacco products in the past?	<input type="checkbox"/>	<input type="checkbox"/>			

MEDICAL LIMITATIONS- SAFETY AND HEALTH	YES	NO
Do you need assistance to climb a ladder?		
Do you have difficulty climbing 2 flights of stairs?		
Do you have difficulty walking for 30 minutes without resting?		
Would you have difficulty jumping safely from a 2-foot height?		
Do you have problems at high altitude?		
Do you have difficulty wearing a tightly fitting respirator/mask?		
EXPLANATIONS: Explain any "YES" answer from above. Please describe the condition and/or the approximate date of occurrence.		



MEDICAL HISTORY FORM

PIPELINE #

PARTICIPANT NAME:

Alcohol	Yes	No	If abstinent, please enter date of your last alcoholic beverage (or NONE): (YYYY or NONE) Describe frequency and type of alcohol: Describe "yes" answers to alcohol questions:
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever felt you should decrease your alcohol consumption?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever received a DUI, DWAI or court ordered treatment for alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been diagnosed and/or treated with an addiction or alcohol related disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
Exercise and conditioning	Yes	No	Describe frequency and type of exercise: Date of last Exercise Stress Test (CST): (MM/YYYY)
Do you have a regular exercise program?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a cardiovascular stress test?	<input type="checkbox"/>	<input type="checkbox"/>	

Reason for CST:

GENERAL MEDICAL HISTORY

New Government regulations require that you be informed of the following:

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Therefore, you should not forward any information related to your family's medical history and only submit answers to these questions regarding your own personal/individual history.

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY

Condition		Yes	No	Condition		Yes	No
1	Neurology			2D	Congestive heart failure		
1A	Cerebrovascular accident (CVA)			2E	Coronary angioplasty/stent/bypass		
1B	Concussion			2F	Coronary artery disease		
1C	Dizziness/Loss of Consciousness			2G	Heart murmur/valvular heart disease		
1D	Headaches (Migraine)			2H	Hypertension (high blood pressure)		
1E	Headaches (Other)			2I	Myocardial Infarction (MI)		
1F	Multiple sclerosis			2J	Supraventricular tachycardia (SVT)		
1G	Peripheral neuropathy			2K	Other cardiac condition		
1H	Seizures			3	Vascular disease		
1I	Transient ischemic attack (TIA)			3A	Abdominal aneurysm		
1J	Traumatic brain injury (TBI)			3B	Arterial emboli		
1K	Other neurological disorder			3C	Cerebral aneurysm		
2	Cardiology			3D	Deep venous thrombosis (DVT)		
2A	Angina/chest pain			3E	Venous stasis ulcers		
2B	Atrial fibrillation			3F	Other vascular condition		
2C	Cardiac pacemaker/defibrillator						



MEDICAL HISTORY FORM

PIPELINE #

PARTICIPANT
NAME:

For all "yes" answers provide details to include line number, age of onset, frequency of event, date of last episode, current medications, other therapies and current status of the condition.



MEDICAL HISTORY FORM

PIPELINE # _____

PARTICIPANT
NAME: _____

GENERAL MEDICAL HISTORY

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY

	Condition	Yes	No		Condition	Yes	No
4	Rheumatologic & Autoimmune disease			8I	Irritable bowel syndrome (IBS)		
4A	Fibromyalgia			8J	Pancreatitis		
4B	Osteoarthritis			8K	Peptic ulcer disease		
4C	Rheumatoid arthritis			8L	Ulcerative colitis		
4D	Systemic Lupus erythematosus			8M	Other gastrointestinal disease		
4E	Other Rheumatologic/Autoimmune condition	<input type="checkbox"/>	<input type="checkbox"/>	9	Dermatology		
5	Ears, Nose and Throat			9A	Dermatitis		
5A	Hearing impairment			9B	Melanoma		
5B	Nosebleeds			9C	Psoriasis/Eczema		
5C	Seasonal Allergies			9D	Skin cancer		
				9E	Other skin condition		
6	Ophthalmology			10	Orthopedic		
6A	Glaucoma			10A	Cervical spine injury		
6B	Visual impairment			10B	Chronic pain		
6C	Other eye condition			10C	Dislocation		
6D	Lasik/restorative surgery			10D	Fractures		
7	Pulmonary			10E	Low back injury		
7A	Altitude sickness			10F	Joint replacement/pins/plates		
7B	Asthma after 10 years of age			10G	Other orthopedic condition		
7C	Chronic bronchitis/bronchiectasis			11	Metabolic		
7D	Chronic obstructive pulmonary disease			11A	Adrenal insufficiency		
7E	Dyspnea (shortness of breath)			11B	Diabetes Type I		
7F	Obstructive sleep apnea			11C	Diabetes Type II		
7G	Pulmonary embolism			11D	Gout		
7H	Positive TB Test/Treatment			11E	Hypercholesterolemia		
7I	Chronic cough (greater than 3 weeks)			11F	Hyperthyroidism		
7J	Night sweats			11G	Hypothyroidism		
7K	Unexplained weight loss			11H	Pituitary insufficiency		
7L	Exposed to anyone with known TB			11I	Other hormonal disorder		
7M	Other pulmonary condition			12	Gynecology-female		
8	Gastro intestinal disease			12A	Menstrual period over 30 days ago?		
8A	Black tarry stools/Blood in stool			12B	Date of last PAP smear		
8B	Cholelithiasis (gall stones)			12C	Premenstrual syndrome (PMS)		
8C	Crohn's disease			12D	Endometriosis		
8D	Frequent or persistent diarrhea			12E	Severe menstrual cramps		
8E	Gastroesophageal reflux (GERD)			12F	Ovarian cysts		
8F	Hemorrhoids			12G	Sexually transmitted disease		
8G	Hepatitis (describe below)			12H	Other gynecological conditions		
8H	Hernia			12I	HIV		
				12J	Use of hormonal medication		



MEDICAL HISTORY FORM

PIPELINE #

PARTICIPANT
NAME:

For all "yes" answers provide details to include line number, age of onset, frequency of event, date of last episode, current medications, other therapies and current status of the condition. Please indicate reason for hormonal medication if used for other than contraception.



PIPELINE #

PARTICIPANT
NAME:

NPI #
Client Bill #

DOB:

Age:

Sex Assigned at Birth, on
original birth certificate:

Dear Lab Collection (LabCorp or Physician),

This person is being considered for participation in the National Science Foundation’s Arctic or Antarctic program. Collect specimens for the indicated laboratory analyses: **All results need to be translated to English.**

Participant: Do not eat or drink for 8 hours before labs.

**Required Polar Panel
(LabCorp Summer Panel #)**

- Complete Blood Count with Differential
- Blood Chemistries (Na; K; Cl; Ca; Glucose, Serum; Creatinine, Serum; GFR/BUN)
- Hepatic Panel (Alkaline Phosphatase; Total Bilirubin; AST (SGOT); ALT (SGPT))
- Lipid Panel (Cholesterol; HDL; LDL; Triglycerides)
- Hepatitis B Total Core Antibody
- Hepatitis C Antibody
- RPR (Syphilis)
- Blood Type (ABO and Rh)

Additional Labs (Labcorp Winter Panel #)

- PSA (**LabCorp Test #**)
Males 50 and older and wintering at South Pole
- HgA1c (**LabCorp Test #**)
Diabetes I or II or borderline glucose level
- Quantiferon TB (**LabCorp Test #**)
Positive TB skin test or BCG vaccine
- MMR Titer (**LabCorp Test #**)
Required for all first time participants
- HIV (**LabCorp Pane #**)
Winter at South Pole or volunteering for the walking blood bank
- TSH (**LabCorp Test #**)
Winter at South Pole or hyper/hypothyroidism
- Ferritin(**LabCorp Test #**)
Winter at South Pole
- Uric Acid (**LabCorp Test #**)
Winter at South Pole or diagnosed with Gout
- Other: Quantiferon TB (LabCorp Test #)

Additional Information:

If our Medical Director’s NPI # or account # was used to collect the lab work (UTMB) will be able to access these results directly from LabCorp. You can get a copy of your labs at <http://patient.labcorp.com> Please allow a few days to get your lab into their system. Once you have signed up it may take a few hours before you see your results.



PIPELINE #

PARTICIPANT
NAME:

**Dear Medical
Provider:**

DOB:

Age:

**Sex Assigned at Birth, on
original birth certificate:**

This person is being considered for participation in the National Science Foundation’s Arctic or Antarctic program. Polar medical facilities have limited diagnostic and therapeutic capabilities. In the event of a severe injury or medical emergency, transportation to a modern hospital or clinic may take several days or longer. Environmental conditions in the Polar Regions may be harsh. Temperatures range from 30 degrees above to 100 degrees below zero Fahrenheit. Physiologic altitude varies from 0 to over 10,000 feet above mean sea level. Participants may live in close quarters for extended periods of time in constant daylight or darkness. Your clinical assessment will be used to determine the person’s physical qualification for deployment to the Polar Regions. Conduct the indicated tests and provide the results to the Participant in English.

Vaccinations

- TDap (Pertussis)
- Influenza vaccine: Yearly (The United States Antarctic Program will require injections (shots) as the only method of compliance for the flu vaccine requirement.)
- COVID-19 (Must meet up to date status with the current CDC recommendations)

Testing (Summer, Baseline)

- Medical Self History (sign pages 5 and 13, initial pages 12 and 13 after printing)
- Polar Physical Examination (pages 8-9 of this form)
- Quantiferon. **Chest x-ray does not take place**
- EKG - 12 lead with tracing (new participants; every five years if aged 40-49, and yearly if 50+)
- Exercise Stress Test with MD Interpretation (if wintering at South Pole: every two years if 50-59, yearly if 60+) **(Bruce Protocol - must complete 9 minutes, stage 3, 85% max heart rate)**
- Pulmonary Function Test, Pre/Post Bronchodilator (Asthma after 10 years of age)
- Occupational Pulmonary Function Test (Spirometry)
- Guaiac Stool Test (yearly 50+ yrs or older)
- Lab Collection

Testing (Winter)

- Pap Smear Cytology Report with Endocervical Cell Report (South Pole wintering over required every 3 years for women ages 21-65)
- Mammogram Radiology Report (South Pole wintering Over required every 2 years for women ages 40 and over)
- Chest X-ray: **2 View AP/LAT** (Every 5 years if there is a history of smoking >15 years; or if wintering over at South Pole) **(Final Radiology Report Only: do not submit x-ray films)**
- Gallbladder Ultrasound (Required for wintering at South Pole, McMurdo, and Summit Station) **(fast for a minimum of 6 hours before test; report only)**
- Lab Collection

Prescription medications (type and quantity) are limited at all Polar medical facilities. Participants are required to bring a sufficient supply of medications for the duration of their deployment or make the necessary arrangements for shipment of medication in accordance with provided guidelines found within the Polar Physical Qualification Important Information attachment.

After the examination, return the Medical History, Polar Physical Examination Form and ALL results to the Participant so they can include it with this packet. It’s the responsibility of the Participant to return all results to Center for Polar Medical Operations, Antarctic Support Contract, University of Texas Medical Branch (UTMB) at Galveston, in English. **FAX: 409-772-3600**. For questions, please contact UTMB at polmedpq@utmb.edu or 1-855-300-9704 (toll free). Thank you, University of Texas Medical Branch –Center for Polar Medical Operations



POLAR PHYSICAL EXAMINATION FORM

PIPELINE # _____

PARTICIPANT
NAME: _____

Examiner – Comment on all abnormal findings

Examiner – Comment on overall fitness and health conditions that might interfere with the Participant’s ability to participate in a remote polar deployment.

- Overall fitness of the participant is good.
- Participant is able to participate and complete duties in a remote polar environment.
- Participant will require further evaluation prior to clearance. (Comment or Recommendation)

Examiner’s Name (printed with credentials)

Signature

Date

This exam is void without credentials.

Examiner Street Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone: _____ Office Fax: _____

Return the completed examination form and results of the requested tests to the Participant.



PIPELINE #

PARTICIPANT
NAME:

Dear Dentist:

This person is being considered for participation in the National Science Foundation’s Arctic or Antarctic program. The Polar Regions are isolated and lack dental facilities. Participants must be free of dental disease. There must be no caries, active periodontal disease, potential endodontic disease, prosthetic deficiencies, potentially symptomatic wisdom teeth, or any uncompleted treatment. All dental work must be completed and documented. All results are to be given to the Participant so he or she can return the results to the Center for Polar Medical Operations, Antarctic Support Contract, University of Texas Medical Branch (UTMB) at Galveston and/or University of Colorado Polar Medicine.

Following the dental exam, the candidate should provide documentation of:

<p>I. DENTAL EXAM</p>	<p>Chart all existing restorations, missing teeth, and endodontically treated teeth only on the Dental Examination Form. The treating dentist must sign the Dental Examination Form and document all completed work. Please include the completed periodontal evaluation chart to accompany dental exam form and digital x-rays.</p>
<p>II. THIRD MOLARS</p>	<p>Treatment <u>must be completed three weeks prior to deployment</u> in order for the dental condition to stabilize before deployment. Third molars must be extracted only if they are symptomatic or any of the following are present:</p> <ol style="list-style-type: none"> 1. Periodontal probe can contact the crown of an unerupted third molar 2. Bleeding or poor hygiene is evident in the third molar area 3. Pseudo pockets, bony pockets are present 4. Soft tissue extends onto the occlusal surface of the third molar 5. 5. Partially erupted third molars, patient age less than 30 years
<p>III. RADIOGRAPHS</p>	<p>Digital radiographs can be e-mailed in high-resolution JPEG format (preferred) to POLMEDPQ@UTMB.EDU. Original mounted radiographs can be included with the Dental Exam Form. Copies or poor quality radiographs will not be accepted. Radiographs become a part of the participant’s USAP record and WILL NOT BE RETURNED. You may wish to use a double film pack to retain original radiographs for yourself. Necessary radiographs include:</p> <ol style="list-style-type: none"> 1. Set of four ORIGINAL bitewing x-rays mounted – showing crestal bone and all posterior teeth and contacts clearly. These films must be taken within 12 months of PQ packet submission and must accompany the completed examination form. 2. Panoramic and/or mounted full mouth survey – a one time requirement. 3. A periapical (PA) film of all endodontic work, crowns, and extensive restorations
<p>IV. ORTHODONTICS</p>	<p>Orthodontic care is not available in the Polar Regions; so, Participants with fixed orthodontic appliances or undergoing any active treatment may be considered for short deployments, but only with written approval from the attending provider and approval from the ASC Dental Reviewer.</p> <ol style="list-style-type: none"> 1. Unrestricted Clearance – Fixed or removable orthodontic retainer only, with no active appliance. 2. Restricted Clearance for deployments up to six months – Candidates undergoing orthodontic treatment who do not require treatment for the period of deployment and who have not had active treatment for two months prior to deployment.
<p>V. PERIODONTAL EVALUATION</p>	<p>Must be completed and periodontal disease must be treated if or any of the following are present:</p> <ol style="list-style-type: none"> 1. Advanced periodontal disease. 2. Bleeding pockets 5mm or more mm depth. 3. Mild bone loss.

After the examination, return the Polar Dental Examination Form, Periodontal chart, X-rays and ALL results to the Participant. It is the responsibility of the Participant to return all results to Center for Polar Medical Operations, Antarctic Support Contract, University of Texas Medical Branch (UTMB) at Galveston. For additional questions, contact UTMB at polmedpq@utmb.edu or 1-855-300-9704 (toll free).

Thank you,
University of Texas Medical Branch – Center for Polar Medical Operations



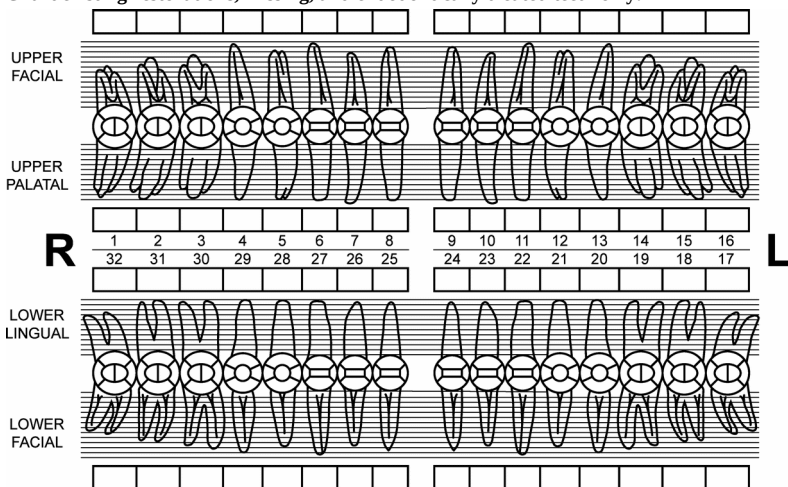
PIPELINE #

PARTICIPANT NAME:

POLAR DENTAL EXAMINATION

Name: Date of Birth: Age:
Day Telephone #: Email Address:
Last Deployment Dates: Estimated Deployment Dates:
From: To: From: To:

Chart existing restorations, missing, and endodontically treated teeth only:



PERIODONTAL EVALUATION

Probing 5 mm or greater YES NO
Active Disease Noted YES NO
Adv. Periodontal Disease YES NO
Bone Loss YES NO

THIRD MOLAR EVALUATION

3rd Molars Present YES NO
List partially erupted
List impacted that can be probed
List fully impacted
List potentially symptomatic
List implants
List retained 1° teeth

Itemized Documentation of all treatment identified and rendered and original digital radiographs must accompany this form

Table with 4 columns: DATES, Diagnosis and treatment needed, DATES, List all treatment completed

Attach the following ORIGINALS to this exam:

PANO OR FULL MOUTH SERIES
Required first deployment only.

Date of last Pano or Full Mouth Series:

BITEWING X-RAYS, SET OF FOUR MOUNTED SHOWING ALL POSTERIOR TEETH

Date taken: X-Ray cannot be older than 12 months at the time of dental review by UTMB

I have thoroughly examined this candidate for travel to the Polar Regions. All necessary treatment has been performed; all evaluations completed; and the appropriate diagnostic radiographs will accompany this completed form as requested by the "Dear Dentist" letter.

DENTIST'S NAME (PLEASE PRINT)

TELEPHONE NUMBER (include area code):

DENTIST'S SIGNATURE

DATE

STREET ADDRESS

CITY

STATE

ZIP

ATTENTION EXAMINING DENTIST:

Return this completed form, all documentation of treatment and all ORIGINAL X-rays (digital preferred) to the Participant.

POLAR MEDICAL STAFF USE ONLY

PQ WINTER REVIEW NPQ



PIPELINE #

PARTICIPANT
NAME:

UNITED STATES ANTARCTIC PROGRAM/ARCTIC PROGRAM DEPLOYMENT CONSENT/AUTHORIZATION DOCUMENTS

IMPORTANT NOTICE FOR PARTICIPANTS IN THE UNITED STATES ANTARCTIC PROGRAM

Participants in the United States Antarctic Program (USAP) are expected to comport themselves in such a manner that their activities and demeanor reflect credit on themselves and their sponsoring organizations. The special circumstances and conditions prevailing in Antarctica and the Arctic require high standards of conduct.

The potential for mishap in the Polar Regions is a constant threat. Your ability to deal effectively with a mishap is reduced if you are under the influence of alcohol or other drugs. The National Science Foundation (NSF) will not condone abuse of alcohol or controlled substances at its facilities. Unauthorized or excessive use of such substances will not be tolerated.

The laws of the United States prohibit the possession, shipping, or mailing of illegal drugs. In addition, governments in New Zealand, South American countries, and Arctic countries have strict laws forbidding the possession or transportation through their countries of firearms, knives, pornographic materials, marijuana or non-prescription drugs. These laws are strictly enforced and penalties for violation are severe. Like any traveler, you must abide by applicable foreign law. If you are found in violation thereof, you are subject to prosecution in the courts of that country. Association with the Antarctic and Arctic programs affords neither preferential treatment nor immunity from prosecution.

Conviction for any criminal action under the laws of the United States or foreign countries may result in your removal from participation in the Antarctic and Arctic programs.

_____ I have read and understand this *Important Notice for Participants in the United States Antarctic Program*
Initials *and the Arctic Program.*

MEDICAL RISKS FOR NSF-SPONSORED PERSONNEL TRAVELING TO ANTARCTICA AND THE ARCTIC

Travel to Antarctica and the Arctic imparts certain risks to the traveler. You may experience extremely cold (subzero) temperatures, high altitude and other environmental conditions that put you at risk for cold-related and/or other injuries. The limitations in the medical care available and difficulties, in emergencies, of providing timely evacuation to tertiary medical care facilities in the U.S. or other countries increase your risk of serious complications from exposure or lack of immediate medical care.

Extremes of daylight and darkness can impact sleep or other behaviors. Living in close quarters increases the likelihood of exposure to communicable diseases. Participants should consider these risks before deciding to deploy.

United States Antarctic Program. Virtually all medical care to USAP participants is provided through the USAP medical care system. Medical clinics operate at all three year-round stations (McMurdo, South Pole, and Palmer Stations). Emergency medical technicians and dispensary operations are available on the two oceanographic research vessels. First-aid/first responders support larger seasonal remote field camps. The three clinics are comparable to a small community hospital emergency room and ambulatory care facility, but without secondary or tertiary care facilities nearby for patient referral or specialist support. Radiography (X-rays) and selected laboratory tests are available in the clinics, but more sophisticated imaging procedures and diagnostic tests are not. Operating room surgical suites are not available at the stations, although each clinic has a triage/trauma room. The USAP does not maintain a frozen blood supply at each station, relying instead on a “walking blood bank” (where individual donors would provide fresh blood if transfusions were needed and blood types matched). The evacuation of critically ill or injured patients from Antarctic sites to sophisticated medical care off the continent (to New Zealand, South America, or the United States) is difficult during the austral summer and may be impossible during the austral winter (February through August).

Arctic. A contracted paramedic is on staff at Summit Station on the Greenland Ice Cap. Facilities for emergency care are available (although rarely used) at Kangerlussuaq (western) and Thule Air Base (northern) in Greenland. Virtual or other emergency health care support may be made available for certain remote Arctic locations; e.g., medical kits and access to medical advice via satellite telephone. Researchers and support personnel at other Arctic locations, such as Alaska, Canada, Russia, etc., are typically able to avail themselves of locally available commercial care. Partly because of these limitations, NSF requires medical and dental screening of personnel prior to deployment. These medical screening examinations are necessary to determine the presence of medical conditions that could threaten the health or safety of the individual while deployed. They are also necessary to determine whether medical conditions exist that cannot be effectively managed while the individual is deployed. Persons who fail to meet these medical/ dental screening criteria will be notified of the specific reason(s) for their disqualification. Disqualified individuals may request reconsideration by completing a waiver application (obtained from the University of Texas Medical Branch or University of Colorado Polar Medicine).



PIPELINE #

PARTICIPANT NAME:

Participants should realize that serious accidents or injuries might challenge the medical care system. Therefore, individuals should recognize the limitations in the medical care system before they engage in any risk-taking behaviors (whether on-the-job or during recreational pursuits) that may result in accidents or injuries.

Data collected as a result of this medical screening requirement are maintained in accordance with the Privacy Act (5 U.S. Code 552a) and protected against unauthorized release, as described in the appended Privacy Notice found in the Polar Physical Qualification Important Information Packet. The collection of this information must display a currently valid OMB control number. You are not required to respond to the collection of this information unless it displays a currently valid OMB control number.

____ I have read and understand the *Medical Risks for NSF-Sponsored Personnel Traveling to Antarctica and the Arctic.*
Initials

MEDICAL SCREENING FOR BLOOD-BORNE PATHOGENS

As described above, medical clinics at the three U.S. Antarctic research stations and the NSF research stations in the Arctic do not have or maintain readily available supplies of frozen blood. In the event of the need for a transfusion, other individuals at the research station with matching blood types would be asked to donate fresh whole blood for the patient. In order to maintain a viable donor pool, NSF requests that U.S. Antarctic and Arctic program participants during the respective austral summer seasons voluntarily submit to testing for Human Immunodeficiency Virus (HIV) along with the required Hepatitis virus B and C as part of their medical screening process. Please note that HIV testing is required for candidates intending to spend the winter in Antarctica or in the Arctic. [Whether you are voluntarily consenting to this testing (summer only) or required to do so (winter deployment), you should take this form with you to your laboratory appointment to ensure that the tests are performed.]

CONSENT FOR HIV ANTIBODY BLOOD TEST

I have been informed that my blood will be tested for Human Immunodeficiency Virus (HIV) antibodies, the causative agent of Acquired Immune Deficiency Syndrome (AIDS). I understand that the testing involves the withdrawal of a small amount of my blood by venipuncture and subsequent testing of that blood sample via ELISA (Enzyme-Linked Immuno-Sorbent Assay) and Western Blot methods.

I understand that if I have any questions regarding the testing procedure or interpretation of results, I should discuss them with my health care provider. I understand that my examining physician will receive a copy of these test results and may be required, under State law, to report positive test results to state health department authorities, and I consent to these disclosures.

I understand that the results of this blood test will be incorporated into my USAP medical file. All information in that file is maintained in accordance with the Privacy Act (5 USC 552a) and protected against unauthorized release, as described in the appended Privacy Notice found in the Polar Physical Qualification Important Information Packet.

I volunteer for the Walking Blood Bank, should a medical emergency develop while I am on station that requires a blood donation to help save a human life. Yes No

____ I have read and understand the above *Medical Screening for Blood-Borne Pathogens information.*
Initials

____ Having read and understood the above statements, I hereby GIVE DO NOT GIVE
____ my consent to the collection and testing of my blood to determine the presence of HIV antibodies if required.
Initials

____ I have read and understand the *United States Antarctic Program/Arctic Program Deployment Consent/Authorization Documents.*
Signature



PIPELINE # _____

PARTICIPANT
NAME: _____

AUTHORIZATION FOR TREATMENT OF FIELD-TEAM MEMBER/PARTICIPANT UNDER 18 YEARS OF AGE

I am the parent or legal guardian of _____, who is an underage participant in the National Science Foundation/Geosciences/Division of Polar Programs. Should any medical/dental care be required during his or her deployment to Antarctica or to the Arctic, I hereby give my authorization and consent to the National Science Foundation's Division of Polar Programs' medical care provider(s) for any medical care, treatment or procedures that are deemed medically necessary while my son or daughter is deployed to either the Arctic or the Antarctic.

Name of Parent or Legal Guardian

Street Address

City State

Zip Code

Telephone Numbers

Daytime: _____ Evening: _____

Print Name

Signature

Date