WILDERNESS AWARENESS SCHOOL

Participant Medical Record and Physician Examination Form

Name: ________________________ Birthdate: ___________

Age: _______ M / F (circle one)

Program: ____

SECTION I: *To be completed by Participant/Guardian*

Past and Present Medical Problems

Do you have, or have you had, any of the following conditions or symptoms?

#	Condition	Yes	No	#	Condition	Yes	No	#	Condition	Yes	No
1.	High Blood Pressure	❑	❑	16.	Circulation Problem	❑	❑	30.	Sleepwalking	❑	❑
2.	Heart Disease	❑	❑	17.	Active Bedwetting	❑	❑	31.	Broken Bones	❑	❑
3.	Tuberculosis	❑	❑	18.	Headaches, Head	❑	❑	32.	Neck Problem	❑	❑
4.	Hepatitis (past or present)	❑	❑		injury w/neurological	❑	❑	33.	Back Problem	❑	❑
5.	Seizure Disorder	❑	❑		impairment	❑	❑	34.	Arm Problem	❑	❑
6.	Bleeding/Blood Disorder	❑	❑	19.	Frostbite	❑	❑	35.	Shoulder Problem	❑	❑
7.	Chronic Cough	❑	❑	20.	Stomach Ulcers	❑	❑	36.	Knee Problem	❑	❑
8.	Recurrent lung infections	❑	❑	21.	Intestinal Problems	❑	❑	37.	Ankle Problem	❑	❑
9.	Asthma	❑	❑	22.	Heatstroke	❑	❑	38.	Leg Problem	❑	❑
10.	Diabetes	❑	❑	23.	Bladder Infection	❑	❑	39.	Foot Problem	❑	❑
11.	Hypoglycemia	❑	❑	24.	Kidney Problems	❑	❑	40.	Currently Pregnant	❑	❑
12.	Anorexia Nervosa	❑	❑	25.	Thyroid Problems	❑	❑	41.	Special Diet	❑	❑
13.	Bulimia	❑	❑	26.	Endocrine Problems	❑	❑	42.	Learning Disability	❑	❑
14.	Cancer	❑	❑	27.	Hearing Impairment	❑	❑	43.	Medical Equipment/Devices	❑	❑
15.	Skin Problems	❑	❑	28.	Vision Impairment	❑	❑	44.	Unexplained weight loss	❑	❑
				29.	Motion Sickness	❑	❑	45.	Other __________________	❑	❑

If you have answered yes to any of the above items please explain below.

Item #	Detailed Description

Allergies (include medicines, food, insect bites and stings) NONE _____

Allergy-List Below	Reaction	Medication Required (if any)

Dietary Restrictions (i.e. No Dairy, Meat, Gluten etc.)

____

____

Medications You Are Currently Taking NONE ____

Include psychiatric (including within the last two months), over the counter and inhalers, recent changes in medication taken

Medication	Taken For	Dosage (size/frequency)	Date Started	Side Effects

Note: if you will be taking medications on the program, bring double amounts in separate, waterproof, non-breakable, waterproof containers along with dosage instructions.

Swimming Ability ❑ Can't Swim ❑ Moderate Ability ❑ Excellent Swimmer

Immunization

We recommend current tetanus immunization (within last 10 years).

Immunization	Recommendation	Date of Last Immunization
Tetanus	within 10 years of course start	

Hospitalizations/Emergencies/Urgent Care

Please list any hospital, emergency department, or urgent care visits within the past two years.

Date of visit/admittance	Reason	Length of Stay

Personal History

Include relevant mental health/therapy information

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Additional Comments/ Other Relevant Health Concerns

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SECTION II: PHYSICIAN EXAMINATION RECORD

To be filled out by a physician

Note to the Examining Physician:
The program for which this individual is applying includes rigorous physical activity in a wilderness setting. This medical examination form is designed to ensure that participants can safely engage in a program's activities. Any person of normal physical and mental capacity can be expected to complete our programs successfully. Please review the participant's medical history and evaluate whether this individual has any conditions that might preclude a successful experience on a rigorous backcountry expedition. This exam must happen within two years of the participant's program start date.

Patient Name: ____________________________________ Exam Date: ______________

Height: ________ Weight: _________ Pulse: _________ Blood Pressure: ___________

√ if normal		Describe if Abnormal	√ if normal		Describe if Abnormal
Eyes	❑	______________________	Back	❑	______________________
Ears	❑	______________________	CNS	❑	______________________
Nose	❑	______________________	Lymph nodes	❑	______________________
Throat and Mouth	❑	______________________	Skin	❑	______________________
Neck	❑	______________________	Scars	❑	______________________
Thyroid	❑	______________________	Extremities	❑	______________________
Thorax and lungs	❑	______________________	Shoulder	❑	______________________
Heart	❑	______________________	Knees	❑	______________________
Abdomen	❑	______________________	Ankles	❑	______________________
Hernia	❑	______________________	Feet	❑	______________________
Genitals	❑	______________________	Other	❑	______________________

Summary of Active Medical Problems and Restrictions

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Other Comments

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Check One: Participant Able to Participate __ Participant Not Able to Participate __

Physician Signature Required

Physician Name: ____

Physician Signature: _____________________________________ Date of exam: ____________

Address: ____

Phone Number: Email Address: