



**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 may include rigorous physical activity in a wilderness setting. Some **ADULT** programs may involve a fast from food for up to 3 days. This medical examination form is designed to ensure that participants can safely engage in a program's activities. Any person with 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 one year 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	<input type="checkbox"/> _____	Back	<input type="checkbox"/> _____
Ears	<input type="checkbox"/> _____	CNS	<input type="checkbox"/> _____
Nose	<input type="checkbox"/> _____	Lymph nodes	<input type="checkbox"/> _____
Throat and Mouth	<input type="checkbox"/> _____	Skin	<input type="checkbox"/> _____
Neck	<input type="checkbox"/> _____	Scars	<input type="checkbox"/> _____
Thyroid	<input type="checkbox"/> _____	Extremities	<input type="checkbox"/> _____
Thorax and lungs	<input type="checkbox"/> _____	Shoulder	<input type="checkbox"/> _____
Heart	<input type="checkbox"/> _____	Knees	<input type="checkbox"/> _____
Abdomen	<input type="checkbox"/> _____	Ankles	<input type="checkbox"/> _____
Hernia	<input type="checkbox"/> _____	Feet	<input type="checkbox"/> _____
Genitals	<input type="checkbox"/> _____	Other	<input type="checkbox"/> _____

**Summary of Active Medical Problems and Restrictions**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Other Comments**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**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: \_\_\_\_\_