

## High Adventure Activity Medical Form

Attach to Participant's Health and Medical Form

(Valid for 12 months from the date signed by the medical professional)

Participant Name \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  
 Emergency Contact  
 Name \_\_\_\_\_ Phone # \_\_\_\_\_

### Health Examination

To be completed by a Licensed Health-Care Provider

**The applicant will be participating in a strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge, or wilderness expedition (afloat or afoot) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue, and/or remote condition where readily available medical care cannot be assured.**

Date of Exam _____	<u>Vision</u>	<u>Hearing</u>
Height _____ Weight _____	Normal _____	Normal _____
B.P. ____/____ Pulse _____	Glasses _____	Abnormal _____
	Contacts _____	

Check box, if normal; circle if abnormal and give details below:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Growth, development | <input type="checkbox"/> Teeth, tonsils         | <input type="checkbox"/> Genitourinary    |
| <input type="checkbox"/> Skin, glands, hair  | <input type="checkbox"/> Respiratory            | <input type="checkbox"/> Skeletomuscular  |
| <input type="checkbox"/> Head, neck, thyroid | <input type="checkbox"/> Cardiovascular         | <input type="checkbox"/> Neuropsychiatric |
| <input type="checkbox"/> Eyes, ears, nose    | <input type="checkbox"/> Abdomen, hernia, rings | <input type="checkbox"/> Other (specify)  |

**COMMENTS** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Dietary Restrictions \_\_\_\_\_

Approved for participation in:

- |   |   |
|---|---|
| <input type="checkbox"/> Hiking             | <input type="checkbox"/> Water Activities |
| <input type="checkbox"/> Competitive Sports | <input type="checkbox"/> All activities   |

Specify exceptions \_\_\_\_\_  
 \_\_\_\_\_

Recommendations (explain any restrictions OR limitations) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is medication information on Health Form up to date and current?    YES    NO  
 If no, please provide updated information. Attach a separate sheet if needed. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Licensed Health-Care Practitioner

Address \_\_\_\_\_ Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_