Wilderness Institute Confidential Medical Information

These activities are strenuous and require physical exertion. We do not want you to engage in activities that could be detrimental to your health or which would be opposed by your doctor because of recent illness or surgery. The following information helps us to be aware of potential problems so we will be better able to help you enjoy the Wilderness Institute.

PART I. GENERAL INFORMATION

Name_____

Sex. M___ F ___ Date of Birth:_____/_____/_____ Height_____ Weight_____

Address: _____
Street City / State Zip

Phone # : (_____)_____

Insurance Company _____Policy # _____

Street Address_____City/State/Zip_____
Does your insurance company require preauthorization? Y N If yes, Phone # (____)_____

PART II. MEDICAL HISTORY

Please check the appropriate column.
Have you ever had any of the following?

YES	NO		
____	____	Allergies	If yes please explain_____
____	____	Diabetes	
____	____	Heart Disease or Cardiac conditions_____	
____	____	Epilepsy	
____	____	Asthma	If yes, do you carry an inhaler?_____
____	____	High Blood Pressure	
____	____	Back Problems	
____	____	Dislocations	If yes, where?_____
____	____	Do you get cold easily?	
____	____	Do you currently smoke?	
____	____	Are you a former smoker?	When did you Quit?_____
____	____	Are you pregnant?	
____	____	Are you currently under a doctor's care?	
		For what reasons?_____	
____	____	Are you currently taking any medications?	
		If yes what type?_____	
____	____	Have you ever had an allergic reaction to insect bites or stings?	
		If so, do you carry medication?_____	
____	____	Are there any limitations on your physical activities?	
		If so, what are they?_____	

Any special dietary requirements?_____

Please list all drugs or foods you are allergic to:_____

PART III. EMERGANCY CONTACT

In the event of an injury or illness, please indicate who should be contacted:

Name:_____Relationship:_____

Address:_____

Home phone: (_____)_____Work phone:(_____)_____

PART IV. CARDIOVASCULAR FITNESS ASSESSMENT

Please carefully answer the following questions.

A. Vital Signs/Statistics

Age_____ Height_____ Weight_____
Blood pressure (taken within 6 months) BP_____/_____ Date taken_____
If systolic is over 150 and/or diastolic is over 90, please have a second reading taken.
2nd BP_____/_____

B. Cardiovascular Risk Factors

Yes	No	
____	____	High blood pressure, even if being treated with medication
____	____	Smoker
____	____	Diabetic requiring medication
____	____	Known abnormally high cholesterol level or on a special diet or medication for a lipid abnormality
____	____	Family history (parents/siblings) of heart attack, coronary artery bypass, angioplasty, or sudden unexplained death before age 55
____	____	Unexplained chest pain/pressure, shortness of breath, heart palpitations, sweats, dizziness from exertion, or faint spells

PLEASE READ AND SIGN

I affirm that the confidential medical information that has been provided is accurate and complete. I understand that failure to disclose this information could affect my own safety and those around me, and I agree to hold Radford University harmless if full disclosure of a pre-existing medical condition has not been provided. In the event of illness or injury, consent is hereby given to provide emergency medical care, hospitalization or other treatment that may become necessary.

PARTICIPANT'S SIGNATURE _____DATE_____

Any additional information you think we should know, List below:

PART V. HEALTH EXAMINATION

THIS SECTION IS TO BE FILLED OUT BY A LICENSED HEALTH-CARE PRACTITIONER

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

Please insist applicant finish complete medical history before exam.

Date _____
Ht._____Wt._____
B.P._____/_____Pulse_____

Vision:
Normal_____
Glasses_____
Contacts_____

Hearing:
Normal_____
Abnormal_____

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

- ❑ Growth, development
- ❑ Skin, glands, hair
- ❑ Head, neck, thyroid
- ❑ Eyes, ears, nose
- ❑ Teeth, tonsils
- ❑ Respiratory
- ❑ Cardiovascular
- ❑ Abdomen, hernia, rings
- ❑ Genitourinary
- ❑ Skeletomuscular
- ❑ Neuropsychiatric
- ❑ Other (specify)

Comments_____
_____
_____
_____
_____
_____

The Participant is approved for his or her participation in:

- ❑ Strenuous Hiking with heavy pack
- ❑ White Water activities
- ❑ Competitive sports
- ❑ Camping for extended period
- ❑ Rock climbing

Specify exceptions _____
Recommendations (explain any restrictions or limitations): _____
_____

Signed_____Date_____

Licensed health-care Practitioner