NatureBridge

To submit, email completed form to alcoascholars@naturebridge.org

Medical Exam (to be filled out by a Physician, LNP, or PA)

IMPORTANT NOTE REGARDING THE MEDICAL EXAM: Applicants may wait until they receive preliminary acceptance into the program to obtain a medical exam (acceptances will be announced April 3). For applicants who are offered a position in the program, medical exams are due on April 17th. *If you choose to wait to get a medical exam, please be sure to still schedule it now.* Applicants will not be fully accepted into the program until the NatureBridge medical form is reviewed and approved by NatureBridge staff; **those who are given preliminary acceptance but have not submitted their NatureBridge medical exam by April 17th will forfeit their position in the program.**

*** This form ***must*** be used – **alternate forms will not be accepted.** ***

This page is to be completed and signed by a Physician, Licensed Nurse Practitioner, or Physician's Assistant.

To the examining physician:

Our summer backpacking program is strenuous. We hike approximately 5-10 miles (8-16 km) daily at high altitudes (8,000 ft./2,500 m) with 30-50 pound (13-18 kg.) packs. Our participants can be far removed from hospital-based medical support services and as much as 48 hours from definitive care.

Your careful examination is an important part of our medical screening process. By signing this form you indicate that the participant is in good physical condition, adequate for successfully participating in our strenuous summer backpacking trips.

Please fill out completely.

Exam Date_____ ***NOTE: Exam must take place within <u>one year</u> of program start date.***

Patient's Name _____

Height _____ (*circle* ft./cm.) Weight _____ (*circle* lbs./kg.) Blood Pressure _____/_____ Pulse_____

Circle if normal, describe only if abnormal:

Eyes_____ Ears _____

Nose _____ Throat & Mouth _____

Thyroid _____ Lymph nodes _____

Neck _____ Back _____

Extremities _____ Shoulders _____

Knees _____ Ankles _____

Feet _____ Skin _____

Heart _____ Other _____

Summary of Active Medical Problems and Restrictions

Please list below or circle: None

_____

_____

_____

_____

Conditions and Symptoms

Does the patient have or have they had any of the following conditions or symptoms?

1. Tuberculosis	☐ Yes ☐ No	11. Kidney Infection	☐ Yes ☐ No	21. Ankle problem	☐ Yes ☐ No
2. Chronic Cough	☐ Yes ☐ No	12. Thyroid Problems	☐ Yes ☐ No	22. Knee problem	☐ Yes ☐ No
3. Asthma	☐ Yes ☐ No	13. Hearing Impairment	☐ Yes ☐ No	23. Broken bones	☐ Yes ☐ No
4. Diabetes	☐ Yes ☐ No	14. Vision Impairment	☐ Yes ☐ No	24. Motion sickness	☐ Yes ☐ No
5. Hypoglycemia	☐ Yes ☐ No	15. Circulation Problems	☐ Yes ☐ No	25. Learning disability	☐ Yes ☐ No
6. Recent exposure to active TB	☐ Yes ☐ No	16. Respiration Issues	☐ Yes ☐ No	26. Medical Equipment/ Devices	☐ Yes ☐ No
7. Positive TB Test	☐ Yes ☐ No	17. Headaches	☐ Yes ☐ No	27. Special diet	☐ Yes ☐ No
8. Active Hepatitis	☐ Yes ☐ No	18. Intestinal Problems	☐ Yes ☐ No	28. Sleepwalking	☐ Yes ☐ No
9. Seizure Disorder	☐ Yes ☐ No	19. Bladder Infection	☐ Yes ☐ No	29. Eating disorder	☐ Yes ☐ No
10. Bleeding Disorder	☐ Yes ☐ No	20. Skin Problem	☐ Yes ☐ No	30. Other:	

If you have answered "yes" to any of the above items, please explain below. Include the following:

- What specific symptoms are occurring
- Date of last occurrence
- How you care for symptom/condition
- How long symptom/condition lasts
- How often symptom/condition occurs
- How symptom/condition restricts applicant's activity in any way (including applicant's ability to hike)

NOTE: If Patient has **severe** asthma or **severe** allergies, please provide an asthma or anaphylaxis emergency action plan.

Item No.	Detailed Description (including restrictions, if any)

Physician's Signature Required

How long have you known the applicant? _____

Name of examining Physician (please print): _____

Address: _____Telephone: _____ Fax: _____

Physician's Signature _____ **Date** _____