NatureBridge

Summer Backpacking

Medical Exam

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

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

To the examining physician:

Our summer backpacking program is strenuous in nature. We hike approximately 5-10 miles daily at high altitudes with 30-50 pound 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 ____ft. ____in. Weight _____lbs. 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 long symptom/condition lasts
- How you care for symptom/condition
- 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** _____