

1. IDENTIFICATION Age: _____ Sex: _____

Name: _____ Date of _____
Last Name First Name Initial Birth:

Address: _____

City & State: _____ Zip: _____

Health/Accident Insurance _____ Policy No. _____

IN AN EMERGENCY NOTIFY:

Name: _____ Relationship: _____

Address: _____ Home Phone: _____

City & State: _____ Business Phone: _____

Personal Physician: _____ Phone: _____

2. EMERGENCY MEDICAL INFORMATION

Has or is subject to (check and give details):

- Allergy to a medicine, food, plant, animal, or insect toxin
- Any condition that may require special care, medication, or diet
- Asthma Heart Trouble
- Diabetes Bleeding Disorder
- Convulsions Fainting Spells

EXPLAIN: _____

3. IMMUNIZATION

	Last Year Given
TETANUS	_____
DIPHTHERIA	_____
POLIO	_____
_____	_____
Has had	Vaccination Disease
Measles	_____
MUMPS	_____
RUBELLA	_____
PERTUSSIS	_____
CHICKEN POX	_____

4. PHYSICIAN'S EVALUATION AND ADVICE

Approved for participation in:

- Hiking and Camping Water Activities
- Competitive sports All Activities

Specify exceptions: _____

Recommendations: (explain any restrictions OR limitations): _____

Signed: _____ Date: _____

*(Physician licensed to practice medicines)

*Examinations conducted by doctors of osteopathy, doctors of chiropractic, or pediatric nurse practitioners will be recognized in states where they may perform physical examinations to students enrolled in public school systems.

5. MEDICAL HISTORY

- Date of most recent complete physical examination (month and year) _____/_____/_____
- Are you aware of any current health problems? yes no
- Now under medical care or taking medicines? yes no
- Has there been any surgery, illness, allergy, or change in health status since last complete physical examination? yes no

Give dates and full details below for any "yes" answer.

IS THERE DISEASE OF (OR PAST OR PRESENT HISTORY OF):

	No	Yes	Year	Details
Serious illness	No	Yes	_____	
Serious injury	No	Yes	_____	
Deformity	No	Yes	_____	
Surgery	No	Yes	_____	
Skin, Glands	No	Yes	_____	
Ears, Eyes	No	Yes	_____	
Nose, Sinus	No	Yes	_____	
Teeth, Tonsils	No	Yes	_____	
Dentures	No	Yes	_____	
Bridge	No	Yes	_____	
Chest, Lungs	No	Yes	_____	
Heart	No	Yes	_____	
Murmur	No	Yes	_____	
Rheumatic fever	No	Yes	_____	
Stomach, Bowels	No	Yes	_____	
Appendicitis	No	Yes	_____	
Kidneys or Urine	No	Yes	_____	
Albumin	No	Yes	_____	
Sugar	No	Yes	_____	
Infection	No	Yes	_____	
Bed-wetting	No	Yes	_____	
Menstrual problems	No	Yes	_____	
Hernia (rupture)	No	Yes	_____	
Back, Limbs, Joints	No	Yes	_____	
Sleepwalking	No	Yes	_____	
Nervous condition	No	Yes	_____	
Other (explain)	No	Yes	_____	

6. HEALTH EXAMINATION

Physician: _____

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 (afoot or afloat) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue and/or remote conditions where readily available medical care cannot be assured.

- Please insist applicant furnish complete medical history(VT) before exam.
- Review immunizations.
- After completing section 6, summarize any restrictions and/or recommendations in section 2 and 5 above, and sign.

DATE: _____ VISION: _____ HEARING: _____
Normal: _____ Normal: _____
 Ht. _____ Wt. _____ Glasses: _____ Abnormal: _____
 B.P. _____/____ Pulse _____ Contacts _____

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

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

COMMENTS _____

LABORATORY: Urinalysis (Dip stick) Albumin _____ Sugar _____