For Office Use

Project Peak Section_______________ Name_______________

Project Peak Health Form

Dear Project Peak Student,
We are excited to have you participate in Project Peak. It is mandatory that you complete this medical form. It is divided into two sections, section I can be filled out by you, and section II needs to be filled out by a Physician, licensed Nurse Practitioner, or Physician's Assistant. This form will be kept confidential and will only be shared with your instructors. This form WILL NOT be shared with any other offices on campus and unless you pick it up at the end of Project Peak, it will be destroyed.

Section I:

General Information

Name:____

Gender: M F Birthdate:________________ Age as of 8/19/11:______________

Height :______________________ Weight:______________________________

G#:____

Home address:____

City/State/Zip:____

Home phone:______________________ Cell phone:______________________

In case of emergency contact:___________________________________

Relationship:______________________ Home phone:______________________

Work phone:______________________ Cell phone:______________________

Insurance company name:____

Policy #:____

Address:____

City/State/Zip:____

Does your insurance require pre-authorization? Yes ________No_______

If YES, phone number:____

Please include a photocopy of your insurance card

Personal Medical History

Do you have, or have you had any of the following conditions or symptoms? Mark every question (1-21) either YES or NO.

1.	High Blood Pressure	Y	N	12.	Hypoglycemia	Y	N
2.	Heart Disease	Y	N	13.	Anorexia	Y	N
3.	Heart Murmur	Y	N	14.	Bulimia	Y	N
4.	Irregular Digestion	Y	N	15.	Cancer	Y	N
5.	Tuberculosis	Y	N	16.	Skin Problems	Y	N
6.	Hepatitis	Y	N	17.	Circulation Problems	Y	N
7.	Seizure Disorder	Y	N				
8.	Bleeding Disorder	Y	N	18.	Head Injury	Y	N
9.	Blood Disorder/Anemia	Y	N	19.	Head Aches	Y	N
10.	Asthma	Y	N	20.	Stomach Ulcers	Y	N
11.	Diabetes	Y	N	21.	Intestinal Problems	Y	N

22. Heatstroke	Y	N	34. Shoulder Problems	Y	N
23. Bladder Infection	Y	N	35. Knee Problems	Y	N
24. Kidney Problems	Y	N	36. Ankle Problems	Y	N
25. Thyroid Problems	Y	N	37. Leg Problems	Y	N
26. Allergy to Iodine	Y	N	38. Neck Problems	Y	N
27. Hearing Impairment	Y	N	39. Currently Pregnant	Y	N
28. Vision Impairment	Y	N	40. Special Diet	Y	N
29. Sleep Walking	Y	N	41. Learning Disability	Y	N
30. Broken Bones	Y	N	42. Uses Medical Equip/ device	Y	N
31. Foot Problems	Y	N	43. Has had Surgery	Y	N
32. Back Problems	Y	N	44. Cold Sores	Y	N
33. Arm Problems	Y	N	45. Chronic/Frequent Illness	Y	N
			46. PMS or Menstrual problems	Y	N
			47. Other________________________		

If you answered YES to any of the listed conditions/symptoms, please explain below. Include specific information about how long the condition lasted, dates of occurrence, and treatment. How do(es) these condition(s) affect your ability to hike, climb, swim and paddle?

Item Number **Detailed description**

____
____
____
____
____
____
____
____
____
____

Allergies: Please include food, environmental and drug allergies

Allergy **Reaction** **Medication required**

1.____
2.____
3.____
4.____
5.____
6.____

Medications: Please list any medications you take, including over the counter medications

Medication **Condition** **Dose (size and frequency)** **Side-effects**

1.____
2.____
3.____
4.____
5.____
6.____

Hospitalizations/Emergencies: Please list any hospital or emergency department visits in the last 2 years.

Date **Reason** **Length of Stay**

____
____
____
____

Personal History

1. Have you been in counseling with a psychiatrist, psychologist or other counselor within the past 2 years? Yes__________ No___________
2. Are you currently in counseling/treatment? Yes_________ No_________
3. Reason for counseling (check appropriate response)

_____ Academic _____ Family _____Substance Abuse
_____ Suicide _____ Depression _____Other____________________

Lifestyle

1. Do you use alcohol? Yes______ No______
2. Do you use tobacco? Yes _____ No______
3. Do you currently have a substance abuse/dependency problem? Yes________ No_______

If yes please explain:____

4. Do you have a history of chemical dependency? Yes_____ No______ Drug(s)_____________

Last date of use____________

Current Exercise Activity

Activity **Frequency** **Intensity 1-5 (1–Leisurely, 5–Max exertion)**

____
____
____
____
____

Swimming ability (check one)

__ Non-swimmer ___Cannot swim more than 100 yards ____Moderate swimmer
__Strong Swimmer ____Lifeguard

Additional Student Comments/Concerns

____
____
____

I certify that to the best of my knowledge, the information on this form is complete and accurate.

Student Signature

____ Date__________________________

Parent/Guardian Signature (if student is under 18 years old)

____Date_________________________

Section II:
Physician's Section: To be completed and signed by a Physician, Licensed Nurse Practitioner, or Physicians' Assistant.

Note: this form MUST be used–alternate forms will not be accepted.

To the examining Physician: Your patient will be participating in a 6-day wilderness Adventure trip, to include, hiking, swimming, rock climbing, kayaking and white-water rafting. Anyone in reasonable health and average fitness should be able to complete this course successfully. You are in the position to evaluate and advise the applicant on any medical issues that may affect the applicant on the trip. Thank you!

Patient's name:____
Height______ ft _________ in Weight___________ lbs
Blood Pressure______/_______ (if blood pressure is over 150/90, please repeat)
Pulse rate___________
Pulse irregularities: Yes_______ No________

If yes, describe and indicate significance_______________________________________

Exam: Please check normal, describe ONLY if abnormal

	Normal	**Describe if abnormal**
Eyes	______________	____
Ears	______________	____
Nose	______________	____
Throat	______________	____
Thyroid	______________	____
Thorax/Lungs	______________	____
Heart	______________	____
Abdomen	______________	____
Back	______________	____
CNS	______________	____
Lymphnodes	______________	____
Skin	______________	____
Arms/Legs	______________	____
Joints	______________	____

Physician's summary of active medical problems and restrictions
None_______ or list below

____
____
____

Physician's Signature required
How long have known this applicant?____
On the basis of your knowledge of the applicant, the applicant's medical history, the present physical examination of this applicant, and your knowledge of the wilderness Adventure trip activities in which the applicant will participate, do you believe this individual is able to participate? Yes__________ No________________
Name of Examining Physician____
Address____
Telephone:____
Physician's Signature____