High Adventure Medical Form

Note: This High Adventure Medical Exam Form is **required** for Trail Life USA activities or events that exceed 72 hours in duration or include high altitude or high-exertion activities. A **current** completed Youth or Adult Participant Health and Medical Form MUST accompany this form.

PERSONAL INFORMATION

Participant Name _____ **Date of Birth** _____ **Age** _____

EMERGENCY CONTACTS

Name _____ **Relationship** _____

Home Phone _____ **Cell Phone** _____

Name _____ **Relationship** _____

Home Phone _____ **Cell Phone** _____

HEALTH EXAMINATION

To be completed by a Licensed Health Care Provider.

Date of Exam _____

Height **Weight**

Blood Pressure **Pulse**

Vision

Normal ☐

Glasses ☐

Contacts ☐

Hearing

Normal ☐

Abnormal ☐

	Normal	**Abnormal**	**Explain** *(if abnormal)*		**Normal**	**Abnormal**	**Explain** *(if abnormal)*
Growth, Development	☐	☐		Cardiovascular	☐	☐	
Skin, Glands, Hair	☐	☐		Abdomen, Hernia	☐	☐	
Head, Neck, Thyroid	☐	☐		Genitourinary	☐	☐	
Eye, Ears, Nose	☐	☐		Skeletomuscular	☐	☐	
Teeth, Tonsils	☐	☐		Neuropsychiatric	☐	☐	
Respiratory	☐	☐		Other *(specify)*	☐	☐	

Comments

Dietary Restrictions

Approved for Participation in:

☐ **Hiking** ☐ **Competitive Sports** ☐ **Water Activities** ☐ **All Activities**

Specific exceptions & recommendations *(explain any restrictions OR limitations)*:

MEDICATIONS

To be completed by a Licensed Health Care Provider. *List all medications currently prescribed. (If additional space is needed, please use the back of this page.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only. If none, please write "None" below.*

Medication	Strength	Frequency	Approx Start Date	Reason

The applicant will be participating in strenuous activity/activities 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 (including, but not limited to high humidity, heat and/or extreme cold), cold water, exposure, fatigue, and/or remote condition where readily available medical care cannot be assured. I hereby affirm that upon my examination and the information provided to me by the participant, there are no restrictions or limitations to his participation in the aforementioned strenuous activity/activities.

_____ _____

Signature of Licensed Health Provider *Date*

_____ _____

Printed Name of Licensed Health Provider *Phone*

_____ _____

Address *City, State, Zip Code*

This High Adventure Medical Exam Form is good for one year from the date of the exam by a Licensed Health Care Provider.