

Participant Medical Form

Applicant's Name: _____ Date: ____/____/____

Section Two: For Your Doctor to Complete

This Medical Form must be completed by the participant's doctor once annually.

Medical History:

1. Chronic health problems (e.g. asthma, pressure sores, cough, constipation) and treatments of which the medical staff should be aware: _____

2. Applicant a carrier of Hepatitis B or has he/she been exposed to Hepatitis B: Yes No
If yes, was a lab test conducted to determine the presence of antibodies? Yes No
Were antibodies present? Yes No Physician's initials _____
3. Applicant a carrier of any other infectious or contagious condition: Yes No
Explain: _____
4. Allergies: Yes No Describe: _____
5. Seizures: Yes No Type: _____
Date of the last one: ____/____/____
Are they controlled by medication? Yes No What: _____
Can applicant tell if one is coming on? Yes No How: _____
6. Vitals: Heart problems Heart murmur Irregular heart beat Blood pressure concerns
Explain: _____
Problems at higher elevation: Yes No Explain: _____
7. Applicant's immunization records up-to-date and complete: Yes No
Date of last tetanus shot: ____/____/____

Applicant's Name: _____ Date: ____/____/____

Medications: List all medications currently taken by the applicant. Please attach additional sheet(s) if needed.

Med. Name	Dosage Times	Total/Day	Reason Prescribed
1. _____			
2. _____			
3. _____			

Describe how the applicant best takes the medication(s).

Over the counter ANYTHING: _____
_____ Doses: _____

Vitamins and Herbs: _____
_____ Doses: _____

Restrictions:

1. Has the applicant been hospitalized or treated in an emergency room recently? Yes No
If yes, please explain _____

2. Physical conditions, past operations or injuries which might restrict program activity? Yes No
Explain restrictions _____

3. Pulse Oxide Range _____ to _____

Physician Signature: _____ Date: ____/____/____

Physician's Name (Please Print): _____

Office Phone: _____ Emergency Phone: _____



Send your completed form with PHYSICIAN'S SIGNATURE to:

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