

# Medical Form

3-Day Course

**RETURN**

## Wilderness Based Orientation

Confidential Medical History and Physical Examination  
Record for Participant and Physician  
Wilderness Based Orientation  
Western State College of Colorado  
Gunnison, CO 81231

FOR OFFICE USE ONLY

Follow-up

Approval

Every item in every section must be completed.

Mark N/A if any section is not applicable to you.

Any item or section that is not completed will require written or telephone follow-up. This may jeopardize your place on the trip.

Keep a photocopy of your completed medical form. We cannot readily access this information if you should need it in the months or years following your course.

### PART I. GENERAL INFORMATION (To be completed by applicant)

Name \_\_\_\_\_ WBO Program Name: \_\_\_\_\_

Stu# \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age at trip start \_\_\_\_ WBO Dates: \_\_\_\_\_

Height-\_\_\_\_ft.\_\_\_\_in. Weight \_\_\_\_\_ lbs. Male \_\_\_\_ Female \_\_\_\_ e-mail \_\_\_\_\_

Address \_\_\_\_\_ City/state/ZIP \_\_\_\_\_

Home Phone( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ FAX ( ) \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone( ) \_\_\_\_\_ FAX ( ) \_\_\_\_\_

Father/Guardian \_\_\_\_\_ Mother/Guardian \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City/State/ZIP \_\_\_\_\_ City/State/ZIP \_\_\_\_\_

Title/Occupation \_\_\_\_\_ Title/Occupation \_\_\_\_\_

Home Phone( ) \_\_\_\_\_ Home Phone( ) \_\_\_\_\_

Work Phone( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Cell( ) \_\_\_\_\_ e-mail \_\_\_\_\_ Cell( ) \_\_\_\_\_ e-mail \_\_\_\_\_

Emergency Contact Other than Parent \_\_\_\_\_ Phone Number \_\_\_\_\_

**Please return this completed record**

**by July 15<sup>th</sup> to:**

**Wilderness Based Orientation**

Western State College of Colorado  
600 N. Adams St.  
Gunnison, CO 81231

**Please Note:**

**Each participant is responsible for any medical, rescue and/or evacuation expenses.  
Each participant must have current medical insurance.**

**For our insurance records, answers to the following questions ARE REQUIRED to be supplied in detail.  
(Please bring copies of insurance card and prescription medication card to trip.)**

Is applicant covered by any hospitalization and medical care policy?  Yes  No

Insurance Company Name \_\_\_\_\_

Phone (    ) \_\_\_\_\_

Policy or Certificate # \_\_\_\_\_

Prescription Medication Plan # \_\_\_\_\_

Address of Insurance Company \_\_\_\_\_

Does the insurance company require pre-authorization?  Yes  No

If yes, please give phone # (    ) \_\_\_\_\_

All information will remain confidential. Over the years, many students with a variety of medical/psychological difficulties have successfully completed our courses, but we must be aware of these conditions in order to best serve each participant. Failure to disclose such information could result in serious harm to the applicant and/or his or her fellow students.

If you arrive at the trip start with a pre-existing condition or injury which is not indicated on your medical form and you are subsequently forced to leave the trip because of that condition, you will be charged an evacuation fee and will not receive a refund of tuition.

**Signature Required**

The information provided on the following pages is a complete and accurate statement of the physical and psychological factors which may affect my participation in WBO. I realize that failure to disclose such information could result in serious harm to myself and/or fellow students and agree to indemnify and hold harmless WBO if all relevant information is not disclosed. I also agree to notify WBO should there be any change in my health status prior to my course start.

Consent is hereby given for the applicant to attend a WBO trip and permission is given for any emergency anesthesia, operation, hospitalization or other treatment which might become necessary. I have read the description of WBO and I understand that the program is a physically and mentally strenuous activity in a remote wilderness area, far removed from the facilities of civilization.

\_\_\_\_\_  
Applicant's Signature Date

\_\_\_\_\_  
Both Parent's/Guardian(s) Signature if applicant is under 18 Date

**Part II. Participant History: Past and Present Medical Problems**  
**To be completed by applicant. Fill in EVERY blank. Use additional pages if necessary.**

**A. Conditions and Symptoms:** Do you have, or have you ever had, any of the following conditions or symptoms?

	YES	NO		YES	NO
1. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	36. Endocrine Problems	<input type="checkbox"/>	<input type="checkbox"/>
2. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	37. Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	38. Vision Impairment	<input type="checkbox"/>	<input type="checkbox"/>
4. Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	39. Motion Sickness	<input type="checkbox"/>	<input type="checkbox"/>
5. Family history of heart attack	<input type="checkbox"/>	<input type="checkbox"/>	40. Sleep Walking	<input type="checkbox"/>	<input type="checkbox"/>
6. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	41. Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>
7. Recent exposure to active TB	<input type="checkbox"/>	<input type="checkbox"/>	42. Neck Problem	<input type="checkbox"/>	<input type="checkbox"/>
8. Positive TB test	<input type="checkbox"/>	<input type="checkbox"/>	43. Back Problem	<input type="checkbox"/>	<input type="checkbox"/>
9. Active Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	44. Arm Problem	<input type="checkbox"/>	<input type="checkbox"/>
10. History of Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	45. Shoulder Problem	<input type="checkbox"/>	<input type="checkbox"/>
11. Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	46. Knee Problem	<input type="checkbox"/>	<input type="checkbox"/>
12. Seizure within past year	<input type="checkbox"/>	<input type="checkbox"/>	47. Ankle Problem	<input type="checkbox"/>	<input type="checkbox"/>
13. Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	48. Leg Problem	<input type="checkbox"/>	<input type="checkbox"/>
14. Blood disorder/anemia/ sickle cell trait	<input type="checkbox"/>	<input type="checkbox"/>	49. Foot Problem	<input type="checkbox"/>	<input type="checkbox"/>
15. Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	50. Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
16. Recurrent lung infections	<input type="checkbox"/>	<input type="checkbox"/>	51. Special Diet	<input type="checkbox"/>	<input type="checkbox"/>
17. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	52. Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>
18. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	53. Medical Equipment Devices	<input type="checkbox"/>	<input type="checkbox"/>
19. Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	54. Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>
20. Anorexia Nervosa	<input type="checkbox"/>	<input type="checkbox"/>	55. Other _____		
21. Bulimia	<input type="checkbox"/>	<input type="checkbox"/>			
22. Cancer	<input type="checkbox"/>	<input type="checkbox"/>			
23. Skin Problem	<input type="checkbox"/>	<input type="checkbox"/>	Do you currently or regularly have any of the following symptoms?		
24. Frostbite	<input type="checkbox"/>	<input type="checkbox"/>			
25. Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	56. Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>
26. Active Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>	57. Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
27. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	58. Unexplained Sweating	<input type="checkbox"/>	<input type="checkbox"/>
28. Head injury with neurological impairment	<input type="checkbox"/>	<input type="checkbox"/>	59. Frequent Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
29. Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	60. Frequent Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
30. Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	61. Frequent Fainting	<input type="checkbox"/>	<input type="checkbox"/>
31. Heatstroke	<input type="checkbox"/>	<input type="checkbox"/>	62. Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
32. Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	63. Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>
33. Difficulty Urinating	<input type="checkbox"/>	<input type="checkbox"/>	64. Intolerance of warm temps	<input type="checkbox"/>	<input type="checkbox"/>
34. Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	65. Intolerance of cold temps	<input type="checkbox"/>	<input type="checkbox"/>
35. Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	66. PMS or menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>
			67. Other _____		

If you have answered "YES" to any of the above items, please explain below. Include the following:  
 - What specific symptoms occur                      - How long symptom/condition lasts                      - Date of last occurrence  
 - How often symptom/condition occurs                      - How you care for symptom/condition  
 -How symptom/condition restricts your activity in any way, including your ability to run, lift and climb

Item #	Detailed Description (including restrictions, if any)

**B. Allergies (including medicines, foods, bites and stings)**NONE 

Allergy	Reaction	Medication Required

**C. Medications**

List any medications you are using, including psychiatric and over-the-counter medication.

NONE 

Medication	Taken For	Dosage (size & freq.)	Date Started	Current Side Effects

**NOTE:** If you are receiving medication, bring double amounts in separate, non-breakable waterproof containers along with dosage instructions.

**D. Required Immunization - Tetanus**

Tetanus Immunization must be within ten (10) years of your WBO start date. Date \_\_\_\_\_

**E. Hospitalization/Emergencies**

Please list any hospital or emergency department visits in the last two years.

Dates	Reason	Length of Stay

**F. Personal History:**

1. Have you been in counseling with a psychiatrist, psychologist, or other counselor within the past two years?

Yes  No 2. Are you currently in counseling / treatment with a counselor, psychiatrist, psychologist, or prescribing physician? Yes  No 

3. When was counseling / treatment terminated? Date: \_\_\_\_\_

4. Reason for counseling / treatment (check appropriate responses)

- Academic                       Family Issues                       Depression                       Substance Abuse  
 Eating Disorder                       Career                       Divorce                       Suicide  
 Medication Maintenance                       Other \_\_\_\_\_

5. Please arrange for a release of information with your counselor so we may contact him/her. Have you done so? Yes  No 

6. Name of most recent counselor: \_\_\_\_\_

Phone (    ) \_\_\_\_\_ FAX (    ) \_\_\_\_\_ e-mail \_\_\_\_\_

7. Name of prescribing physician: \_\_\_\_\_

Phone (    ) \_\_\_\_\_ FAX (    ) \_\_\_\_\_ e-mail \_\_\_\_\_





**Wilderness Pursuits/Wilderness Based Orientation  
Participant Acknowledgment & Assumption of Risks  
&  
Release and Indemnity Agreement**

I \_\_\_\_\_, am aware in signing this document for participation in the Wilderness Pursuits and Wilderness Based Orientation (collectively referred to as "WP") program offered through Western State College of Colorado that certain elements of the program are physically and emotionally demanding. Furthermore, I understand that certain risks and dangers, such as those listed below, exist in the activities in which I am participating. These risks may include but are not limited to loss or damage to personal property, injury or fatality due to inclement weather, altitude, lightning, slipping, falling, insect and animal bites, falling objects, immersion in cold water, drowning, hypothermia, or suffering any type of accident or illness in remote areas without easy access to medical facilities or while traveling to and from the activity site. I acknowledge that while this program and its instructors will make every reasonable effort to teach me proper techniques and to minimize exposure to known risks, all hazards and dangers associated with this activity cannot be foreseen. I have personal responsibility to learn and to follow the safety rules and procedures established by my instructors and will make them aware at any point at which I question my knowledge of these procedures or my ability to participate in any activity. I agree to assume all of the risks of the activities of my WP program, whether inherent or not and whether described above or not. **INITIALS** \_\_\_\_\_

I agree not to use tobacco, drugs or alcohol while participating in program activities and understand that doing so will place me and others at risk. **INITIALS** \_\_\_\_\_

I will bring no weapons, make no threats of violence or engage in any conduct that threatens the safety of others. **INITIALS** \_\_\_\_\_

I agree that if I fail to abide by agreements herein, I will be prohibited from further participation in WP programs. **INITIALS** \_\_\_\_\_

I am responsible for all costs incurred due to medical treatments, rescues and evacuations before during and after the program, even when that cost is necessitated by accidents, illnesses or injuries incurred because of risks inherent or not in participation in WP activities. I must provide medical insurance information to WP, and must come to WP with medical insurance information. I have been strongly advised to purchase health insurance prior to participating in WP activities. **INITIALS** \_\_\_\_\_

No refunds are given after the program start date for any reason including changing of program location, activities, itinerary, group size, instructor ratio, curricula, medically based withdrawal of the student, or motivational or psychologically based withdrawal of the student. WP staff may withdraw, expel, and or evacuate any student for any reason. **INITIALS** \_\_\_\_\_

I give Western State College of Colorado, its employees, designees, agents, independent contractors, legal representatives, successors and assigns, and all persons or departments for whom or through whom it is acting, the absolute right and unrestricted permission to take, use my name, testimonial and biographical data and/or publish, reproduce, edit, exhibit, project, display and/or copyright photographic images or pictures of me, in which I may be included in whole or in part, through any form of media (print, digital, electronic, video, television, internet, broadcast or otherwise), for art, advertising, recruitment, marketing, fund raising, publicity, archival or any other lawful purpose. I waive any right that I may have to inspect and approve the finished product that may be used or to which it may be applied now and/or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image or product. **INITIALS** \_\_\_\_\_

I understand and assume all the dangers and risks associated with this program and waive all claims that I may have against the Trustees of the State of Colorado, Western State College of Colorado and their officers, agents and employees (collectively, the "Trustees") directly or indirectly arising out of my participation in this program. I further agree to hold the Trustees harmless from liability for such injury or damage. My signature on this Release and Indemnity Agreement is also intended to bind my successors, heirs, representatives, administrators and assigns. **INITIALS** \_\_\_\_\_

I acknowledge that I have read and understand this agreement and have signed it voluntarily in consideration of the Trustees' agreement to allow me (or my minor child or ward) to participate in this program. **INITIALS** \_\_\_\_\_

If participant is under the age of eighteen at the time this document is signed, a parent or legal guardian must sign the release in addition to the participant's signing.

\_\_\_\_\_  
Participant name (please print)

\_\_\_\_\_  
WSC Student ID#

\_\_\_\_\_  
Date of Birth and Age

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian Signature

\_\_\_\_\_  
Date