

Confidential Medical History and Physical Examination Record for Participant and Physician

Wilderness Based Orientation

Please return this completed record by July 15th to:

Wilderness Based Orientation
Western State College of Colorado
600 N. Adams St.
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 _____

Important: Part III of this form must be completed and signed by a physician, licensed nurse practitioner or physician assistant:

Your place on the trip you choose is confirmed when we receive all forms, filled out and signed, and your full tuition payment. This medical form is a particularly important way we ensure a safe experience for you. The physician's examination must take place within 12 months prior to the course. If we have any question about your capability to complete the course, we will call and discuss it with you and/or your physician. If we think you should not participate in the course, we will refund all tuition payments made to Wilderness Based Orientation (WBO).

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 _____

PART III. Physician Section
To be completed by a Physician, Licensed Nurse Practitioner or Physician Assistant.

To the Examining Physician:

Please take the time to carefully review this form and alert us of any conditions the participant may have that we will need to be aware of. Wilderness Based Orientation (WBO) of Western State College operates trips which are physically and mentally demanding. Students sleep in tents or under improvised shelters. Suitable equipment and ample meals, are provided but we may not be able to meet special dietary requirements. Students are expected to refrain from using tobacco, alcohol or drugs other than prescribed medication. Strenuous physical activity may include:

- walking on uneven terrain
- carrying 45 lb. Packs
- immersion in cold water
- high altitude hiking
- running
- adjusting quickly to altitudes of up to 14,000 ft.

WBO is dedicated to ensuring thorough and comprehensive medical evaluation and screening for all course applicants. In the past, many of our student medical forms were incomplete which necessitated follow-ups and resulted in delays in completing the screening form. The most common problems have been:

- Insufficient detail in Part II (Participant History);
- Inadequate description of abnormalities found in the Physical Exam
- Unanswered questions throughout the screening form.

As the applicant's primary health care provider, you know your patient best and you are in the best position to evaluate and advise the applicant on medical issues. Your input is vital! We are asking you to carefully review the student's medical history and we are asking you to summarize and evaluate any currently active medical problems that can affect the applicant on a WBO trip.

PROCEDURE

1. Please review Part II (Participant History). Check it for accuracy and completeness and make any necessary corrections or additions.
2. After reviewing Part II (Participant History) and after completing your exam, use the space provided to list any currently active medical problems. Summarize any restrictions that you feel are required on a WBO trip. Please pay particular attention to heart, lung and musculoskeletal issues.
3. If you feel that any further tests, immunizations, or specialty referrals are required before the applicant participates in WBO, please indicate in the section provided.

Any individual with normal physical and mental capacity can usually expect to complete a WBO trip, All participants are strongly advised to perform preliminary conditioning. Our goal is to provide this applicant with a fun, rewarding, and safe experience. Thank you for your help.

Sincerely,

Janna Hansen
Director of Wilderness Based Orientation
Western State College of Colorado
600 N. Adams St.
Gunnison, CO 81231
970-943-7051
jhansen@western.edu

C. Pre-Acceptance Testing

Before your patient will be accepted for full WBO participation, we will carefully review this medical form.

Further Tests: If you feel further diagnostic tests are indicated prior to participating in WBO, please schedule and provide results including TB Skin Test, medication blood levels and other tests.

Test	Date	Results: Normal/Abnormal (describe)

D. Required Immunization

Immunization	Requirement	Year of Last Immunization
Tetanus	Within 10 years of course start date	

*If greater than 10 years or unknown, **please** schedule tetanus booster.

Date to be administered: ____/____/____ PLEASE CALL OR SEND CONFIRMATION.

How long have you known the applicant? _____

On the basis of your past knowledge, the applicant's medical history and the present physical examination of this applicant, do you feel this individual can participate in Wilderness Based Orientation? YES NO

Name of examining physician (please print) _____

Address _____

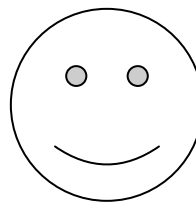
Telephone () _____ FAX () _____

 Physician's Signature Date of Exam
(must be within one year of course starting date)



PLEASE BE SURE YOUR PHYSICIAN SIGNS THIS DOCUMENT AND CHECKS YES OR NO AT THE TOP OF THIS BOX

THANK YOU!



Please Complete and Return by July 15th

**Wilderness Based Orientation
 Western State College of Colorado
 600 N. Adams St.
 Gunnison, CO 81231
 970-943-2702 Fax**



**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