Wilderness Pursuits/WBO
Medical Form

FOR OFFICE USE ONLY

Follow-up
Approval

Participant Confidential Medical History
Wilderness Based Orientation
Western State Colorado University
Gunnison, CO 81231

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 15th to:
Wilderness Based Orientation
Western State Colorado University
University Center 120
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
1. High Blood Pressure	☐	☐
2. Heart Disease	☐	☐
3. Heart Murmur	☐	☐
4. Irregular Heartbeat	☐	☐
5. Family history of heart attack	☐	☐
6. Tuberculosis	☐	☐
7. Recent exposure to active TB	☐	☐
8. Positive TB test	☐	☐
9. Active Hepatitis	☐	☐
10. History of Hepatitis	☐	☐
11. Seizure Disorder	☐	☐
12. Seizure within past year	☐	☐
13. Bleeding Disorder	☐	☐
14. Blood disorder/anemia/ sickle cell trait	☐	☐
15. Chronic cough	☐	☐
16. Recurrent lung infections	☐	☐
17. Asthma	☐	☐
18. Diabetes	☐	☐
19. Hypoglycemia	☐	☐
20. Anorexia Nervosa	☐	☐
21. Bulimia	☐	☐
22. Cancer	☐	☐
23. Skin Problem	☐	☐
24. Frostbite	☐	☐
25. Circulation Problems	☐	☐
26. Active Bed wetting	☐	☐
27. Headaches	☐	☐
28. Head injury with neurological impairment	☐	☐
29. Stomach Ulcers	☐	☐
30. Intestinal Problems	☐	☐
31. Heatstroke	☐	☐
32. Bladder Infection	☐	☐
33. Difficulty Urinating	☐	☐
34. Kidney Problems	☐	☐
35. Thyroid Problems	☐	☐

	YES	NO
36. Endocrine Problems	☐	☐
37. Hearing Impairment	☐	☐
38. Vision Impairment	☐	☐
39. Motion Sickness	☐	☐
40. Sleep Walking	☐	☐
41. Broken Bones	☐	☐
42. Neck Problem	☐	☐
43. Back Problem	☐	☐
44. Arm Problem	☐	☐
45. Shoulder Problem	☐	☐
46. Knee Problem	☐	☐
47. Ankle Problem	☐	☐
48. Leg Problem	☐	☐
49. Foot Problem	☐	☐
50. Currently Pregnant	☐	☐
51. Special Diet	☐	☐
52. Learning Disability	☐	☐
53. Medical Equipment Devices	☐	☐
54. Unexplained weight loss	☐	☐
55. Other_____		
_____		

Do you currently or regularly have any of the following symptoms?

56. Chest Pain/Pressure	☐	☐
57. Heart Palpitations	☐	☐
58. Unexplained Sweating	☐	☐
59. Frequent Shortness of Breath	☐	☐
60. Frequent Dizziness	☐	☐
61. Frequent Fainting	☐	☐
62. Heartburn	☐	☐
63. Muscle Cramps	☐	☐
64. Intolerance of warm temps	☐	☐
65. Intolerance of cold temps	☐	☐
66. PMS or menstrual problems	☐	☐
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_____

G. Lifestyle

1. Do you use alcohol? YES ☐ NO☐
2. Do you use tobacco? YES ☐ NO ☐
3. Do you currently have a substance abuse problem (alcohol, drugs, etc.)? YES ☐ NO☐
   If yes, please describe_____
4. Do you have a history of substance dependency? YES ☐ NO ☐ Substances: _____
5. Last used? _____Date_____

H. Current Exercise Activity/Fitness

1. Please list current exercise activity. Note: You do not have to be an athlete to attend WBO.
   Our students come at varying levels of condition.

Activity	Frequency	Approximate Time/Distance	Leisurely	Moderately	Intensely

Comments (optional) _____
_____
_____
_____
_____

2. Swimming Ability ☐ Non-Swimmer ☐ Cannot swim more than 100 yards ☐ Moderate Swimmer
   ☐ Strong Swimmer ☐ Current life-saving Certificate

Blood Pressure _____Resting Pulse_____

Blood Pressure and Pulse Rate are **REQUIRED** for all courses

Please list any food allergies or special dietary needs:
_____
_____
_____
_____
_____

Additional Participant Comments:
_____
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