ETC Youth LEAD Program

Participant/Physician Confidential Medical Record

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. Choosing to overlook a section on this form may jeopardize your place on the course.

Your place on the course is confirmed when we receive all forms, filled out and signed, and your full tuition payment. This medical form is important to ensure a safe experience for you. The physician's examination (if applicable) must take place within 12 months prior to the course.

PART I

APPLICANT INFO

Name_____

Social Security_____

Gender: _____

DOB _____ / _____ / _____

Age at Course Start_____

Height_____ feet _____ inches

Weight _____ pounds

Parent/Guardian

(Mother or primary guardian)

Name_____

Relationship_____

Address_____

City/State/Zip_____

_____

Occupation_____

Home

Phone_____

Mobile

Phone_____

Work

Phone_____

Fax_____

Email_____

Parent/Guardian

(Father or Additional guardian)

Name_____

Relationship_____

Address_____

City/State/Zip_____

_____

Occupation_____

Home

Phone_____

Mobile

Phone_____

Work

Phone_____

Fax_____

Email_____

_____

FAMILY PHYSICIAN

NAME_____

Telephone

(_____)_____

Fax #

(_____)_____

For our insurance records, answers to the following questions are required in full detail.

Emergency Contact (not parent/guardian)

Name_____Relationship_____

Phone Daytime (____) _____Evening (____)_____

Cell Phone (_____)_____Email (_____) _____

Address_____ Apt # _____

City/State/Zip_____

1. Is the applicant covered by any hospitalization and medical care policy? ☐ Yes ☐ No

2. Insurance Company Name_____

   Policy or Certificate # _____

   Address of Insurance Company_____

3. Does the insurance require pre-authorization? ☐ Yes ☐ No

   If yes please provide phone # ( )_____

All information will remain confidential, and you should know that over the years, many students with a variety of medical/psychological disabilities have successfully completed our courses, but we must be aware of these conditions for the applicant's benefit. Failure to disclose such information could result in the serious harm to the applicant and her or his fellow students.

A note to parents:
If your child arrives at the course start with a pre-existing condition or injury which is not indicated on your medical form you run the risk of having her/him removed from the trip. If the same unreported condition presents, during the wilderness trip, you will be responsible for transport of your child back to your home.

Signature Required

Consent is hereby given for the applicant to attend a ETC Youth Leadership School course and permission is given for any emergency anesthesia, operation, hospitalization, or other treatment, which may become necessary. I have read the description Youth Leadership School Part III, Physician section, of this medical form, and I understand that the program is a physically and mentally strenuous activity in wilderness areas, far from the facilities of civilization.

The information provided on the following pages is a complete and accurate statement of the physical and psychological factors, which may affect my participation on ETC's Youth Leadership School. I realize that failure to disclose such information could result in serious harm to myself and fellow students and agree to indemnify and hold Environmental Traveling Companions harmless if all relevant information is not disclosed. I also agree to notify ETC should there be any change in my health status prior to my trip start

_____

Parent/Guardian's Signature (if applicant is under 21) **Date**

_____

Applicant's Signature

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 had, any of the following conditions or symptoms?

		YES	NO			Yes	No
1.	High Blood Pressure	❒	❒	22	Cancer	❒	❒
2.	Heart Disease	❒	❒	23	Skin Problem	❒	❒
3.	Heart Murmur	❒	❒	24	Frostbite	❒	❒
4.	Irregular Heartbeat	❒	❒	25	Circulation Problems	❒	❒
5.	Family history of heart attack	❒	❒	26	Active Bedwetting	❒	❒
6.	Tuberculosis	❒	❒	27	Headache_	❒	❒
7.	Recent exposure to active hepatitis	❒	❒	28	Head injury with neurological Impairment	❒	❒
8.	Positive TB test	❒	❒	29	Stomach Ulcers	❒	❒
9.	Active Hepatitis	❒	❒	30	Intestinal Problems	❒	❒
10	History of Hepatitis	❒	❒	31	Heat Stroke	❒	❒
11	Seizure Disorder	❒	❒	32	Bladder Infection	❒	❒
12.	Seizure within past year	❒	❒	33	Difficulty Urinating	❒	❒
13.	Bleeding Disorder	❒	❒	34	Kidney Problems	❒	❒
14.	Blood Disorder/anemia/ Sickle Cell Trait	❒	❒	35	Thyroid Problem	❒	❒
		❒	❒	36	Endocrine Problems	❒	❒
15.	Chronic Cough	❒	❒	37	Hearing Impairment	❒	❒
16	Reoccurring lung infections	❒	❒	38	Vision Impairment	❒	❒
17	Asthma	❒	❒	39	Motion Sickness	❒	❒
18.	Diabetes	❒	❒	40	Sleep Walking	❒	❒
19.	Hypoglycemia (Low blood sugar	❒	❒	41	Broken Bones	❒	❒
20.	Anorexia Nervosa	❒	❒	42	Neck Problem	❒	❒
21.	Bulimia	❒	❒	43	Back Problem	❒	❒

44.	Arm Problem	❒	❒		**Do you currently or regularly have any of the following symptoms?**		
45.	Shoulder Problem	❒	❒	57.	Chest Pain/Pressure	❒	❒
46.	Knee Problem	❒	❒	58.	Heart Palpitations	❒	❒
47,	Ankle Problem	❒	❒	59.	Heart Burn	❒	❒
48.	Foot Problem	❒	❒	60.	Frequent Shortness of Breath	❒	❒
49.	Leg Problem	❒	❒	61.	Frequent Dizziness	❒	❒
50.	Currently Pregnant	❒	❒	62.	Frequent Fainting	❒	❒
51.	Medical Equipment Devices	❒	❒	63.	Muscle Cramps	❒	❒
52.	Learning Disability	❒	❒	64.	Intolerance of warm temps	❒	❒
53.	Special Diet	❒	❒	65.	Intolerance of cold temps	❒	❒
54.	Unexplained weight loss	❒	❒	66.	PMS or menstrual problems	❒	❒
55.	Body Piercing in last 6 mos.	❒	❒	67.	Unexplained sweating	❒	❒
56.	Other	❒	❒	68.	Other	❒	❒

If you have answered "YES" to any of the above items, please explain below. Include the following:
- What specific symptoms are occurring
- how long symptom/condition lasts
- Date of last occurrence
- How often symptom/conditions 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 Descriptions (including restrictions, if any)

B. Allergies (Including medicines, foods, insect bites, and stings)
❒ NONE

Allergy-List Below	Reaction	Medication Required (If any)

C. Medications (List all medications you are using, including psychiatric, over-the-counter, and inhalers.) ❒ **NONE**

Medication	Condition	Dosage (mg. & freq.)	Current Side effects (if any)

D. Hospitalization/Emergencies/Urgent Care please list any hospital, emergency, department within last 2 years

Dates	Reason	Length of stay

E. Lifestyle questions

1. Do you use alcohol? ❒ YES ❒ NO How much/How often? _____
2. Do you use tobacco? ❒ YES ❒ NO How much/How often? _____
3. Do you use drugs on a regular basis? ❒ YES ❒ NO
   Which ones/How often _____
4. Do you have a history or current problem with substance abuse or dependency?
   Substances used: _____
   Last used: _____
5. Have you been on probation or had any involvement with the Justice System?
   ❒ YES ❒ NO
   If yes, Date(s): _____
   Reason: _____

F. Current Exercise Activity/Fitness

1. **Please list the activities you engage in daily or weekly which indicate your current fitness level. You do not have to be an athlete to attend the Youth Leadership School. This section gives us an idea of how much exercise you get on a regular basis and will allow us to contact you if we recommend additional training.**

Activity	Frequency	Approxiinate Time/distance	Leisurely	Moderately	Intensely

2. **<u>Swimming Ability</u>**

❒ Non-Swimmer ❒ Cannot swim more than 100 yards ❒ Moderate Swimmer

❒ Strong Swimmer ❒ Current lifesaving certificate

3. **Additional Participant Comments:**

PART III PHYSICIAN SECTION
(To be completed by Physician, Licensed Nurse Practitioner, or Physician Assistant.)

To the Examining Physician:

We need your help! Environmental Traveling Companions runs 7-28 day wilderness Youth Leadership Schools, which are physically demanding. As the applicant's primary health care provider, you know your patient best and most qualified to evaluate the applicant on medical issues. Our courses include the following physical challenges:

- Sea kayaking on the rolling waters of San Francisco Bay
- Rafting on Class III Rapids
- Walking on uneven terrain
- Carrying 40 pound packs
- Living within the close proximity of 14 other adolescents and adults
- Adjusting to high altitude of up to 10,000 feet

Please take sufficient time to do the following:

1. Please review part II- Student History. Check it for accuracy and completeness and make any necessary corrections/additions

2. After conducting your exam, use the space provided to list any currently active medical problems. Summarize any restrictions that you feel are required on an ETC extended wilderness trip especially concerning heart lung and musculoskeletal issues.

3. If you feel any further tests, immunizations, or specialty referrals are required before this summer's ETC trip please indicate in the space provided.

Our central mission is to open the outdoors to as many people as possible so your information will be used as the primary resource for health information as opposed to a method that will preclude your patient's involvement on our trips.

Your time and effort will help ensure the safety for your patient and for all the trips participants.

Many thanks for your help,

-The staff of Environmental Traveling Companions
Based in the San Francisco Bay Area and offering assessable adventures for over 30 years

A. Physician Exam (**This form MUST be used - alternative forms will NOT be accepted**.)

1. Patient's Name _____

2. Height _____ ft. _____ in. 3. Weight _____ lbs. Overweight? _____ lbs. Underweight? _____ lbs.

3. Blood Pressure _____ /_____ IF BP is over 150/90 repeat. Second Reading _____ Date _____

4. Pulse Rate _____ 6. Pulse Irregularities ❒ YES ❒ NO

If yes, please describe and indicate clinical significance _____

7. Exam Date _____/_____/_____ Must be within one year of program start date (See page 1)
Next Sheet➡

Physician Exam (Continued)

Check if normal, describe ONLY if abnormal

	Normal	Describe if abnormal
Eyes_____	❒	_____
Ears_____	❒	_____
Nose_____	❒	_____
Throat & Mouth___	❒	_____
Neck_____	❒	_____
Thyroid_____	❒	_____
Thorax_____	❒	_____
Heart_____	❒	_____
Heart Murmur (if present) -Functional	❒	_____
Peripheral Vessels	❒	_____
Abdomen	❒	_____
Hernia	❒	_____
Genitals	❒	_____
Back	❒	_____
CNS	❒	_____
Lymph Nodes	❒	_____
Skin	❒	_____
Scars	❒	_____
Extremities	❒	_____
Shoulder	❒	_____
Knees	❒	_____
Ankles	❒	_____
Feet	❒	_____

Other_____

B. Immunization

Immunization	Recommendation	Date of last immunization
Tetanus	Current Within last 10 years	

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C. Medications ❒ **NONE**

Medication	Condition	Dosage (mg. & freq.)	Current Side effects (if any)

D. Summary of Active Medical Problems and Restrictions NONE ❒ or list below

Please include any specialty referrals here, immunization updates, and further tests that you feel are recommended.

(To be filled out by physician, use additional page if needed)

_____

_____

_____

_____

_____

_____

Doctor Signature Required Here:

How long have you known applicant _____

Email Address_____

Name of examining physician (please print) _____

Address _____

Telephone ( ) _____ Fax ( ) _____

_____

Physician's Signature Date