

PLEASE RETURN ASAP

UCSC WILDERNESS ORIENTATION MEDICAL FORM

U. C. Santa Cruz, Wilderness Orientation, Office of P.E. & Recreation, Santa Cruz, CA 95064
Phone: (831) 459-2807

Dear Wilderness Orientation Student,

To participate in the Wilderness Orientation Program you are required to complete the following Wilderness Orientation Medical Form. You must use this form; alternate forms will not be accepted. Included are sections that you must complete and a section that involves a physical exam. This physical exam must be completed by a Physician, licensed Nurse Practitioner, or Physician Assistant. Explain what the physical exam is for to the person giving the exam. All questions must be addressed. Mark N/A if any question is not applicable to you. If you have further questions or concerns, please contact us at the number listed above.

SECTION A AND SECTION B: TO BE COMPLETED BY THE STUDENT

SECTION C: TO BE COMPLETED BY A PHYSICIAN, LICENSED NURSE PRACTITIONER OR PHYSICIAN ASSISTANT

NOTE: Have your medical professional review section B after you have completed it

A. General Information To be completed by the student. Please print neatly.

Name _____ Session (1 or 2) _____
Nickname _____ Date of Course _____
Male/Female _____
Birthdate ____/____/____ Age at time of course _____
Height _____ Weight _____

Address _____
City/State/Zip _____
Home _____
Phone() _____

Physician _____ Phone () _____
Address _____
City/State/Zip _____

In case of emergency contact: _____
Address _____
City/State/Zip _____ Relationship _____
Home Phone () _____ Work Phone () _____

Are you covered by any hospitalization/medical care policy? Yes _____ No _____
Insurance Company Name _____ Policy or Certificate # _____
Address _____
City/State/Zip _____
Does Insurance company require pre-authorization? Yes _____ No _____
If yes, phone () _____

FOR OFFICE USE ONLY

Follow-up _____ Seen and Approved _____

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

	Medication	Condition	Dosage (size & freq.)	Current Side Effects
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Required Immunization

Please tell us the year of your last tetanus shot (it must be within 10 years prior to course starting date)
Year _____

Hospitalization/Emergencies

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

	Date	Reason	Length of Stay
1.	_____	_____	_____
2.	_____	_____	_____

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? Yes ___ No ___
- 3. Reason for counseling (check appropriate responses):
 Academic Family Issues Substance Abuse
 Suicide Depression Other _____

Lifestyle

- 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 currently have a substance abuse or chemical dependency problem (Alcohol, drugs, etc...)?
Yes ___ No ___ If yes, please describe: _____
- 4. Do you have a history of chemical dependency? Yes ___ No ___ Drug(s) _____
Last use(date)? _____

Current Exercise Activity (Wilderness Orientation is a physically demanding experience.)

1. Describe your current exercise activities here.

Activity	Frequency	Approximate Time/Distance	Leisurely	Moderately	Intensely
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

Swimming Ability (check one) Non-swimmer Cannot swim more than 100 yards
 Moderate Swimmer Strong swimmer Current lifesaving Cert

Additional Student Comments _____

I certify that to the best of my knowledge, the information on this form is complete and accurate, I also certify that I am aware that Wilderness Orientation is a physically demanding experience

Student Signature (Include parent signature if student is under 18 years) _____ Date _____

C. Physician Section To be completed and signed by Physician, Licensed Nurse Practitioner or Physician Assistant

Physical Exam This form MUST be used - alternate forms will not be accepted

TO THE EXAMINING PHYSICIAN

Your patient will be participating in a 10 day backpack/mountaineering trip held in the Sierra Nevada Mountains. Students will participate in strenuous activities at 8,000 to 11,000 feet including:

- *walking on uneven terrain
- *high altitude hiking
- *beginning rock climbing
- *carrying a 40-50lb. pack
- *exposed to mountain weather
(possible snow or intense sun)

Anyone in reasonable health and of average fitness should be able to complete this course successfully. Please **review section C: Student History with the patient.** You are in the position to evaluate and advise the applicant and us on any medical issues that may affect the applicant on Wilderness Orientation. Thank you!

1. Patient's Name _____
2. Height _____ ft. _____ in.
3. Weight _____ lbs
If overweight _____ lbs
If underweight _____ lbs
4. Blood Pressure _____ / _____
If BP is over 150/90, please repeat.
Second Reading _____ / _____ Date _____ / _____ / _____
5. Pulse Rate _____
6. Pulse Irregularities: Yes _____ No _____
If yes, please describe and indicate clinical significance: _____

7. Exam:
Check if normal, describe ONLY if abnormal.

	Normal	Describe, if abnormal
Eyes.....	___	_____
Ears.....	___	_____
Nose.....	___	_____
Throat&mouth	___	_____
Neck.....	___	_____
Thyroid.....	___	_____
Thorax&lungs	___	_____
Heart.....	___	_____
Heart murmur (if present)	___	_____
Functional...	___	_____
Peripheral	___	_____
Vessels.....	___	_____
Abdomen.....	___	_____
Genitals.....	___	_____
Back.....	___	_____
CNS.....	___	_____
Lymph nodes...	___	_____
Skin.....	___	_____
Scars.....	___	_____
Extremities...	___	_____
Shoulders.....	___	_____
Knees.....	___	_____
Ankles.....	___	_____
Feet.....	___	_____
Other	___	_____

(continue on next page)

