WILDERNESS LEADERSHIP INSTITUTE

Participant Medical Record

Confidential

To be completed by the applicant

This medical record provides us with information for course safety and emergency response. By requesting this medical history, we do not imply that we have the expertise to assess your physical condition, or your ability to participate safely in this course. *This determination of ability to participate must be made by you, the participant, in concert with your physician.*

PART I General Information

Name_____ Telephone # (_____)_____

Age: _____ DOB: _____/_____/_____ Sex: ☐ Male ☐ Female

Height: _____ft. _____ins. Weight: _____lbs.

Emergency Contact (parent/guardian if under 18)
Name _____
Relationship _____
Daytime Telephone # (_____)_____
Evening Telephone # (_____)_____
Cell Phone # (_____)_____

Family Physician or Health Clinic (circle one)
Name _____
Telephone # (_____)_____
FAX # (_____)_____

Do you speak/understand English?
☐ Yes ☐ No

Insurance Information: Each participant is responsible for any medical expenses and should be covered by his/her own illness and accident insurance.

DO YOU HAVE INSURANCE? ☐ Yes ☐ No

Insurance Company _____ Policy/Certificate # _____

Prescription Plan # _____ Telephone # (_____)_____

Do you wear glasses or contacts? ☐ Yes ☐ No Do you have an extra pair? ☐ Yes ☐ No

Do you have any dietary needs or restrictions? ☐ Yes ☐ No Are you hearing impaired? ☐ Yes ☐ No
(*Please explain any Yes answers below*)

_____

_____

Swimming Ability (check one)

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

☐ Strong Swimmer ☐ Current Lifeguard Certificate

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PART II Participant History: Past and Present Medical Problems

A. Conditions and Symptoms ***(****Please FILL in EVERY blank!)***

#	Condition	Y	N	#	Condition	Y	N	#	Condition	Y	N
1	**High Blood Pressure**			**20**	**Bladder Infection (UTI)**			**39**	**Hernia**		
2	**Heart Disease**			**21**	**Difficulty Urinating**			**40**	**Intestinal Problems**		
3	**Heart Murmur**			**22**	**Kidney Problems**			**41**	**Heatstroke**		
4	**Irregular Heartbeat**			**23**	**Thyroid Problems**			**42**	**Currently Pregnant**		
5	**Family history of heart attack**			**24**	**Head injury with neurological impairment**			**43**	**Headaches**		
6	**Medical Equipment/ Devices**			**25**	**Hearing Impairment**			**44**	**Stomach Ulcers**		
7	**Diabetes**			**26**	**Vision Impairment**			**45**	**Other**		
8	**Hypoglycemia (↓blood sugar)**			**27**	**Motion Sickness**			**Do you currently or regularly have any of the following symptoms?**			
9	**Asthma**			**28**	**Sleep Walking**						
10	**History of Hepatitis**			**29**	**Broken Bones**			**46**	**Chest Pain/Pressure**		
11	**Seizure Disorder/Epilepsy**			**30**	**Neck Problem**			**47**	**Heart Palpitations**		
12	**Seizure w/in past year**			**31**	**Back Problem**			**48**	**Frequent Shortness of Breath**		
13	**Bleeding Disorder**			**32**	**Arm Problem**			**49**	**Frequent Dizziness**		
14	**Blood Disorder/Anemia/Sickle Cell Trait**			**33**	**Shoulder Problem**			**50**	**Frequent Fainting**		
15	**Chronic Cough**			**34**	**Knee Problem**			**51**	**Heartburn**		
16	**Skin Problem**			**35**	**Ankle Problem**			**52**	**Muscle Cramps**		
17	**Frostbite**			**36**	**Leg Problem**			**53**	**Intolerance to Warm or**		
18	**Circulation Problems**			**37**	**Foot Problem**			**54**	**Cold Temperatures**		
19	**Yeast Infection**			**38**	**Concussion (TBI)**			**55**	**PMS/Menstrual Problems**		

If you have answered "yes" to any of the above items, please explain below. Include the following:

- Specific symptoms that are occurring
- How long symptom/condition lasts
- How often symptom/condition occurs
- Date of last occurrence
- How you care for symptom/condition
- How symptom/condition restricts your activity in any way, including your ability to run, lift, and climb

Condition #	Detailed Description (including restrictions, if any)

B. Allergies (Including allergies to medicines, foods, insect bites/stings)

NONE ☐ or…

Allergy List Below	Reaction	Medication Required (if any)

C. Medications You Are Currently Taking (If psychiatric medication, please list any taken within the past 2 months)

NONE ☐ or… please list any medications you are using, including psychiatric, over-the-counter, & inhalers

Medication List Below	Taken For Symptom/Condition	Dosage Size and Frequency	Date Started	Current Side Effects (if any)

NOTE: If you are currently taking any critical prescription medication, bring double amounts in separate, non-breakable, waterproof containers, along with dosage instructions.

Immunization: Medical authorities recommend current tetanus immunization within 10 years.

D. Hospitalizations/Emergencies/Urgent Care

NONE ☐ or… please list any hospital, emergency department, or urgent care visits within the past 2 years

Date of Visit/Admittance	Reason	Length of Stay

E. Current Exercise Activity

Please list the activities you engage in daily or weekly which indicate your current fitness level.

Activity	Frequency	Approximate Time/Distance	Leisurely	Moderately	Intensely

Note: You may be required to engage in rigorous physical activity during your WLI course.