

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

<p>APPLICANT INFO</p> <p>Name _____</p> <p>Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Age at Course Start _____</p> <p>DOB ____ / ____ / ____</p> <p>Height _____ feet _____ inches</p> <p>Weight _____ pounds</p> <p>Parent/Guardian (Mother or primary guardian)</p> <p>Name _____</p> <p>Relationship _____</p> <p>Address _____</p> <p>City/State/Zip _____</p> <p>Occupation _____</p> <p>Home _____</p> <p>Phone _____</p> <p>Mobile _____</p> <p>Phone _____</p> <p>Work _____</p> <p>Phone _____</p> <p>Fax _____</p> <p>Email _____</p>	<p>Parent/Guardian (Father or Additional guardian)</p> <p>Name _____</p> <p>Relationship _____</p> <p>Address _____</p> <p>City/State/Zip _____</p> <p>Occupation _____</p> <p>Home _____</p> <p>Phone _____</p> <p>Mobile _____</p> <p>Phone _____</p> <p>Work _____</p> <p>Phone _____</p> <p>Fax _____</p> <p>Email _____</p> <p>FAMILY PHYSICIAN</p> <p>NAME _____</p> <p>Telephone _____</p> <p>(_____) _____</p> <p>Fax # _____</p> <p>(_____) _____</p>
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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 | <input type="checkbox"/> | <input type="checkbox"/> | 22. Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | 23. _____ Skin Problem | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. _____ Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | 24. _____ Frostbite | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Irregular _____ Heartbeat | <input type="checkbox"/> | <input type="checkbox"/> | 25. _____ Circulation Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Family history of heart attack | <input type="checkbox"/> | <input type="checkbox"/> | 26. _____ Active Bedwetting | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. _____ Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | 27. _____ Headache | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. _____ Recent exposure to active hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | 28. _____ Head injury with neurological impairment | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Positive TB test | <input type="checkbox"/> | <input type="checkbox"/> | 29. Stomach Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. _____ Active Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | 30. _____ Intestinal Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. _____ History of Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | 31. _____ Heat Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. _____ Seizure Disorder | <input type="checkbox"/> | <input type="checkbox"/> | 32. _____ Bladder Infection | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. _____ Seizure within past year | <input type="checkbox"/> | <input type="checkbox"/> | 33. _____ Difficulty Urinating | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. _____ Bleeding Disorder | <input type="checkbox"/> | <input type="checkbox"/> | 34. _____ Kidney Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. _____ Blood Disorder/anemia/
Sickle Cell Trait | <input type="checkbox"/> | <input type="checkbox"/> | 35. _____ Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. _____ Chronic Cough | <input type="checkbox"/> | <input type="checkbox"/> | 36. _____ Endocrine Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. _____ Reoccurring lung infections | <input type="checkbox"/> | <input type="checkbox"/> | 37. _____ Hearing Impairment | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. _____ Asthma | <input type="checkbox"/> | <input type="checkbox"/> | 38. _____ Vision Impairment | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. _____ Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | 39. _____ Motion Sickness | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. _____ Hypoglycemia (Low blood sugar) | <input type="checkbox"/> | <input type="checkbox"/> | 40. _____ Sleep Walking | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. _____ Anorexia Nervosa | <input type="checkbox"/> | <input type="checkbox"/> | 41. _____ Broken Bones | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. _____ Bulimia | <input type="checkbox"/> | <input type="checkbox"/> | 42. _____ Neck Problem | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | <input type="checkbox"/> | <input type="checkbox"/> | 43. _____ Back Problem | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | | _____ | | |

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

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. Immunization (ETC recommends that all YLS participants have current tetanus immunization (within last 10 years.)

Immunization	Recommendation	Date of last immunization
Tetanus	Within last 10 years	

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

Dates	Reason	Length of stay

F. 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: _____

G. 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	Approximate Time/distance	Leisurely	Moderately	Intensely

2. Swimming Ability

Non-Swimmer

Cannot swim more than 100 yards

Moderate Swimmer

Strong Swimmer

Current lifesaving certificate

3. Blood Pressure _____ Resting Rate _____

A quick and inexpensive way to take your own blood pressure and pulse is to take them at a self service blood pressure machine, which are located at most pharmacies and in many supermarkets.

4. 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 _____	<input type="checkbox"/>	_____
Ears _____	<input type="checkbox"/>	_____
Nose _____	<input type="checkbox"/>	_____
Throat & Mouth _____	<input type="checkbox"/>	_____
Neck _____	<input type="checkbox"/>	_____
Thyroid _____	<input type="checkbox"/>	_____
Thorax _____	<input type="checkbox"/>	_____
Heart _____	<input type="checkbox"/>	_____
Heart Murmur (if present)		_____
-Functional	<input type="checkbox"/>	_____
peripheral Vessels	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	_____
Hernia	<input type="checkbox"/>	_____
Genitals	<input type="checkbox"/>	_____
Back	<input type="checkbox"/>	_____
CNS	<input type="checkbox"/>	_____
Lymph Nodes	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	_____
Scars	<input type="checkbox"/>	_____
Extremities	<input type="checkbox"/>	_____
Shoulder	<input type="checkbox"/>	_____
Knees	<input type="checkbox"/>	_____
Ankles	<input type="checkbox"/>	_____
Feet	<input type="checkbox"/>	_____
Other _____		_____

B. 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)

How long have you known applicant _____
Email Address _____
Name of examining physician (please print) _____
Address _____
Telephone () _____ Fax () _____
Physician's Signature _____ Date _____