



IWLS

International Wilderness Leadership School



Physician, F.N.P. or P.A.:

Please check YES or NO for each item. Each question must be answered and please **provide date and details for all "yes" answers.**

General Medical History

Does this person currently have a history of:

1. Respiratory problems? Asthma? YES NO

Is the asthma well controlled with an inhaler? YES NO

If so, please have the student bring inhaler(s) with them for their course.

What triggers an attack? Last episode? Ever hospitalized? _____

2. Gastrointestinal disturbances? YES NO

3. Diabetes? YES NO

Examiner's specific comments: _____

4. Bleeding, DVT (deep vein thrombosis) or blood disorders? YES NO

5. Hepatitis or other liver disease? YES NO

Examiner's specific comments: _____

6. Neurological problems? Epilepsy? YES NO

7. Seizures? YES NO

8. Dizziness or fainting episodes? YES NO

9. Migraines? Medications, frequency, are they debilitating? YES NO

6-9. Describe frequency, date of last episode, and severity. ? _____

10. Disorders of the urinary or reproductive tract? YES NO

11. Any disease? YES NO

12. Does this person see a medical or physical specialist of any kind? YES NO

IF "yes" please specify the issue(s) and provide name/address of specialist. _____

Questions 13 and 14 are for Female Students Only:

13. Treatment or medication for menstrual cramps? YES NO

14. Is she pregnant? YES NO



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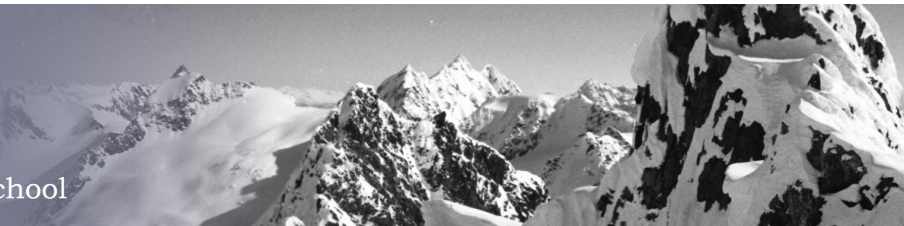
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Examiner's specific comments: _____

15. Hypertension? YES NO

16. Cardiac problems? Unexplained chest pain? YES NO

Examiner's specific comments: _____

Cardiac Screening:

A stress ECG is required if the applicant is:	Cardiac Risk Factors
1. Over 35 years old and has 2 cardiac risk factors. 2. Over 50 years old and has 1 cardiac risk factor. 3. Over 50 years old and leads a sedentary lifestyle. 4. Any age with a known heart condition. Please provide a written note from your doctor stating the date of the stress ECG and the results	<ul style="list-style-type: none"> • High blood pressure • Diabetes • Current or prior cardiovascular disease • High blood cholesterol • Family history of heart disease (family member who's had a heart attack at less than 55 years of age.) • Smoking

The stress ECG requirement may be waived for applicants who are over 50 years of age with no cardiac risk factors and who are in good physical condition. **Their physician must note that the participant has a) no cardiac risk factors and b) excellent cardiac health on page 6 of this form.**

Muscle/Skeletal Injuries/Fractures

Does this person currently have or does he/she have a history within the past 3 years of:

17. Knee, hip or ankle injuries (including sprains) and/or surgery? YES NO

Type of injury or surgery? When did the injury or surgery occur? _____

Is there full ROM? Full Strength? YES NO

What is the most rigorous activity participated in since the injury/surgery. Results? _____

Examiner's specific comments: (include date of last occurrence and the effect of the problem on current activity level) _____

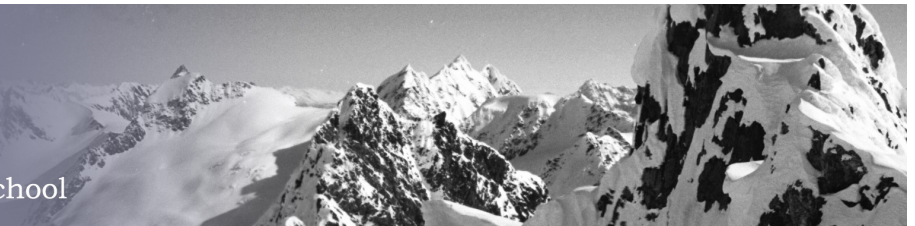
18. Shoulder, arm or back injuries (including sprains) and/or surgery? YES NO





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Type of injury or surgery? When did the injury or surgery occur? _____

Is there full ROM? Full Strength? YES NO

What is the most rigorous activity participated in since the injury/surgery. Results? _____

Examiner's specific comments: (include date of last occurrence and the effect of the problem on current activity level): _____

19. Any other joint problems?

Examiner's specific comments: (include date of last occurrence and the effect of the problem on current activity level): _____

20. Head Injury? Loss of consciousness? For how long? YES NO

Examiner's specific comments: (include date of last occurrence and the effect of the problem on current activity level): _____

21. Does this person have any physical, cognitive, sensory, or emotional condition that would require a special teaching environment? YES NO

If yes, please describe how the condition effects you: _____

Personal History (Counseling/Psychiatric/Learning Disabilities)

IWLS requires that any participant with a counseling history demanding medication, hospitalization or residential treatment, display one year of stability before they will be accepted for a course. They must be successfully employed or in school.

22. Has he/she had treatment, counseling or hospitalization with a mental health professional?

YES NO

23. Is he/she currently in treatment or counseling?

YES NO

24. Reasons for treatment or counseling? (please circle)

suicide

ADD/ADHD

substance abuse/chemical dependency

family issues/divorce

eating disorder (anorexia/bulimia)

depression

academic/career

other _____

Please provide Specific Dates and Details of Counseling Hx and medications that were provided:

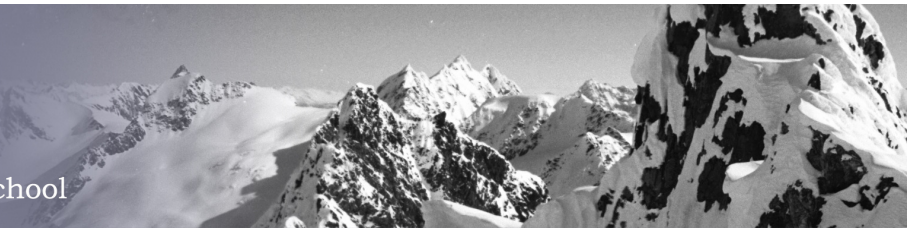
25. Name, address and telephone number of therapist?





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Allergies

26. Is he/she allergic to any foods? YES NO
Describe: _____

27. Are there any dietary restrictions? Please specify YES NO
vegetarian vegan other

28. Allergic to insect bites or bee stings? YES NO
If appropriate please bring 2-3 Epi Pens or Twinjects.
Examiner's specific comments: _____

29. Any other allergies? YES NO
Examiners Specific comments: _____

30. Water may be disinfected with iodine. Is iodine contraindicated? YES NO

MEDICATIONS

31. Is he/she allergic to any medications? YES NO
If yes, please list: _____

32. Does this person plan to take any prescription or non-prescription medications on the course? YES NO

IWLS courses travel in remote areas where access to medical care may be one or more days away. The student must understand the use of any prescription medications they may be taking. Written specific instructions are necessary. All students who are required by their personal physician, psychiatrist or health care provider to take prescription medications on a regular basis must be able to do so on their own and without additional supervision.

Medication	Dosage	Side Effects/Restrictions	Prescribed by?	For what Conditions?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If Medication or Condition Changes Prior to Course Start, Please inform IWLS.

Field staff may administer the following over the counter medications at the appropriate dosage if a student indicates the need for a particular medication (other medications may apply as appropriate). Please indicate if student has any allergies or contraindications to the following medications.

Aspirin, Acetaminophen, Ibuprofen, Psuedoephedrine, Diphenhydramine, Pepto Bismol, Imodium, Tolnaftate (external only)
Monistat-1, Orobace, Cavit, Activated Charcoal



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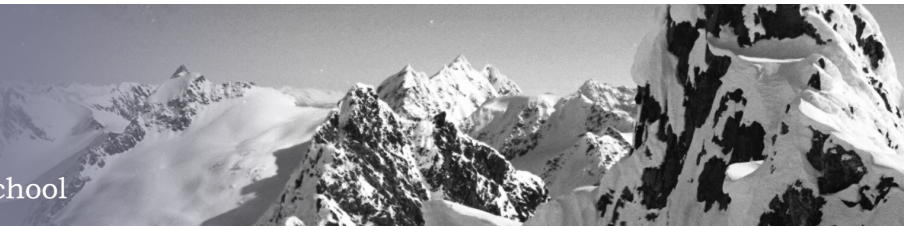
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Field staff may administer the following prescription medications and their appropriate dosage if a student indicates the need for a particular medication (other medications may apply as appropriate). Administration of these medications will be checked off by the IWLS medical director. Please indicate if student has any allergies or contraindications to the following medications.

Ciproflaxin , Azythromax, Ultram, Nifidipene, Acetozolamide, , Dexamethasone.

By my signature, I attest that the information in this form is correct and the person named on page one of this form is medically cleared to participate on a IWLS course based on the expedition information provided on page 1 of this form along with the background information provided by this person and my physical examination of him/her. Additionally, I have reviewed the medications that IWLS carries in the field and noted any exceptions.

COLD, HEAT, ALTITUDE

33. History of frostbite or Raynaud’s Syndrome? YES NO

34. History of acute mountain sickness, high altitude pulmonary/cerebral edema? YES NO

When did the illness occur? _____

35. History of heat stroke or other heat related illness? YES NO

Examiner’s specific comments: _____

Fitness (please provide details concerning the participants exercise regime)

36. Does the applicant exercise regularly? YES NO

Activity _____ Frequency _____

Duration/Distance _____ Intensity Level: Easy Moderate Competitive

Activity _____ Frequency _____

Duration/Distance _____ Intensity Level: Easy Moderate Competitive

37. Is this person overweight? Underweight? If so how much? _____ YES NO

38. Swimming ability (CHECK ONE): Non-swimmer Recreational Competitive

Physical examination

Physician must read and fill out pages 1-6. **Physical examination data cannot be more than a year old from the starting date of the IWLS courses.** (Please type or print legibly)

IWLS Requires a Tetanus Immunization Within 10 Years of the Start Date of the Course. Exceptions Outside the U.S. May Require Additional Immunizations. Please refer to your course description for specific information.





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Blood Pressure

Pulse

Last Tetanus Inoculation

Height

Weight

General Appearance, Impressions and Comments: (If applicable, address cardiac health. See Question #16.):

Examiner's Name

() _____
Phone

Street Address

State

Zip

Physician, F.N.P. or P.A. Signature

Date

By my signature, I attest that the information in this form is correct and the person named on page one of this form is medically cleared to participate on a IWLS course based on the expedition information provided on page 1 of this form along with the background information provided by this person and my physical examination of him/her. Additionally, I have reviewed the medications that IWLS carries in the field and noted any exceptions.



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