TRAIL LIFE USA

This High Adventure Medical Exam Form is **required** for Trail Life USA activities or events that exceed 72 hours in duration or include high altitude or high-exertion activities. **A current** completed Youth or Adult Participant Health and Medical Form MUST accompany this form.

HIGH ADVENTURE Medical Exam Form

Participant's Name Date of birth (MM/DD/YYYY) Age

Emergency Contacts:

Name Relationship

Home Phone # Cell Phone #

Name Relationship

Home Phone # Cell Phone #

Health Examination: **To be completed by a Licensed Health Care Provider**

Date of Exam: ____________________

Height (inches): [ ][ ] . [ ] Weight (pounds): [ ][ ][ ] . [ ]

Blood Pressure: [ ][ ][ ] / [ ][ ][ ] Pulse: [ ][ ][ ]

Vision: Normal ____________ Glasses ________ Contacts ________

Hearing: Normal ____________ Abnormal ____________

	Normal	Abnormal	Explain, if abnormal		Normal	Abnormal	Explain, if abnormal
Growth, development				Cardiovascular			
Skin, glands, hair				Abdomen, hernia			
Head, neck, thyroid				Genitourinary			
Eye, ears, nose				Skeletomuscular			
Teeth, tonsils				Neuropsychiatric			
Respiratory				Other (specify)			

COMMENTS ____

____

Dietary Restrictions ____

Approved for participation in: [ ] Hiking [ ] Competitive Sports [ ] Water Activities [ ] All Activities

Specific exceptions & recommendations (explain any restrictions OR limitations) ____________________

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MEDICATIONS: To be completed by a Licensed Health Care Provider

List all medications currently prescribed. (If additional space is needed, please use the back of this page.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only. If none, please write "None" below.

Medication	Strength	Frequency	Reason

The applicant will be participating in strenuous activity/activities that will include one or more of the following conditions: athletic competition, adventure challenge, or wilderness expedition (afoot or afloat) that may include high altitude, extreme weather conditions (including, but not limited to high humidity, heat and/or extreme cold), cold water, exposure, fatigue, and/or remote condition where readily available medical care cannot be assured. I hereby affirm that upon my examination and the information provided to me by the participant, there are no restrictions or limitations to his participation in the fore stated strenuous activity/activities.

Signature ____ Date ____________
Licensed Health Care Provider

Print Name of Licensed Provider ______________________________ Phone ____________

Address ____

City, State, Zip ____

This High Adventure Medical Exam Form is good for one year from the date of the exam by a Licensed Health Care Provider.

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