TRAIL LIFE USA

HIGH ADVENTURE Medical Exam Form

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 Weekend Medical Form for Adults or Youth MUST accompany this 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: _____ Vision Hearing

Height (inches): ☐☐.☐ Weight (pounds): ☐☐☐.☐ Normal _____ Normal _____

Blood Pressure: ☐☐☐ / ☐☐☐ Pulse: ☐☐☐ Glasses _____ Contacts _____ 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) _____

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 aforestated 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 signed by a Licensed Health Care Provider.