NatureBridge™
Connecting Youth to the Natural World™

MEDICAL INFORMATION
Armstrong Scholars Program

Part I: General Information

Participant Name _____

Date of Birth _____ Age at start of Program _____ Grade _____ ☐ **Female**

Address _____ City/State/Zip _____

If a minor: Parent/Guardian's Name _____

Home Phone (_____)_____ Work Phone (_____) _____

EMERGENCY CONTACTS

#1. Name_____ #2. Name _____

Phone # (____)_____ Phone # (_____) _____

Address _____ Address _____

City/State/Zip _____ City/State/Zip _____

Authorization for Treatment : PARENT/GUARDIAN MUST SIGN

If you are under the age of 18 the law requires that we have parent/guardian permission to have medical service should the need arise.

I am a parent having legal custody/the legal guardian of the minor participant named above. I authorize any adult chaperone, or NatureBridge personnel into whose care my child has been entrusted, to consent to any X-ray, examination, anesthetic, diagnosis, treatment, and/or hospital care that may be recommended by a licensed physician and/or dentist. For minor illnesses or injuries, I understand that NatureBridge will attempt to contact me at the earliest practical opportunity. For major illnesses or injuries, NatureBridge will attempt to contact me before the commencement of any medical treatment, unless my child's condition is such that treatment must be commenced immediately before contact with me can be made. Even if I cannot be reached, this authorization remains in full force and effect.

I authorize NatureBridge staff who have received appropriate training to (1) dispense "over the counter medication," including Aspirin, Acetaminophen(Tylenol), Ibuprofen, Benedryl, Neosporin, Pepto-Bismol, and other similar medications; and (2) administer epinephrine via injection for the emergency treatment of anaphylactic shock that may result from an allergic reaction to insect bites, insect stings, food or plants (such as poison oak). This authorization is overseen by the direction of Dr. Stephen Lockhart.

I agree to assume full financial responsibility for any medical care/treatment my child may receive.

Parent/Guardian's Signature _____ Date _____

Insurance Information

Please Note: Each participant is responsible for any medical expenses and should be covered by his/her own sickness and accident insurance. (The following questions must be answered for insurance records.)

Is applicant covered by a hospitalization/medical care policy? ☐**Yes** ☐**No**

Insurance Company Name_____ Policy or Certificate # _____

Address _____ City/State/Zip _____

Does your Insurance Company require pre-authorization? ☐**Yes** ☐**No** If yes, Phone (_____)_____

Part II: Medical History (to be filled out by a Physician, LNP, or PA)

******* This form ***must*** be used – **alternate forms will not be accepted.*****

This page is to be completed and signed by a Physician, Licensed Nurse Practitioner or Physician's Assistant.

To the examining physician:

We at NatureBridge are excited for as many people as possible to attend our programs. We have learned however that careful medical screening is critical to our participants having a fulfilling experience**. Our summer backpacking program is strenuous in nature. We hike approximately 5-10 miles daily at high altitudes with 35-60 pound packs.** Our participants can be far removed from hospital based medical support services and as much as 48 hours from definitive care.

Please review all portions of this form. Some areas are appropriate for participants to fill out. Your careful examination of all the information contained is an important part of our medical screening process**. By signing this form you indicate that the participant is in good physical condition, adequate for successfully participating in our strenuous summer backpacking trips.** Thank you very much for your help.

Please fill out completely.

Exam Date_____ ***NOTE: Exam must take place within six months of program start date.***

Patient's Name _____

Height _____ft. _____in. Weight _____lbs.

Blood Pressure _____/_____ Pulse_____

Circle if normal, describe only if abnormal:

Eyes _____ Ears _____ _____
Nose _____ Throat & Mouth _____ _____
Thyroid_____ Lymph nodes _____ _____
Neck _____ Back _____ _____
Extremities _____ Shoulders _____ _____
Knees _____ Ankles _____ _____
Feet _____ Skin _____ _____
Heart _____ Other _____ _____

Summary of Active Medical Problems and Restrictions – Please list below or circle: None

_____
_____
_____
_____
_____
_____

Conditions and Symptoms: Does the patient have or have they had any of the following conditions or symptoms?

1.	Tuberculosis	☐ Yes	☐ No	11. Kidney Infection	☐ Yes	☐ No	21. Ankle Problem	☐ Yes	☐ No
2.	Chronic cough	☐ Yes	☐ No	12. Thyroid Problems	☐ Yes	☐ No	22. Knee Problem	☐ Yes	☐ No
3.	Asthma	☐ Yes	☐ No	13. Hearing Impairment	☐ Yes	☐ No	23. Broken Bones	☐ Yes	☐ No
4.	Diabetes	☐ Yes	☐ No	14. Vision Impairment	☐ Yes	☐ No	24. Motion Sickness	☐ Yes	☐ No
5.	Hypoglycemia	☐ Yes	☐ No	15. Circulation Problems	☐ Yes	☐ No	25. Learning Disability	☐ Yes	☐ No
6.	Recent exposure to active TB	☐ Yes	☐ No				26. Medical Equipment/Devices	☐ Yes	☐ No
7.	Positive TB Test	☐ Yes	☐ No	17. Headaches	☐ Yes	☐ No	27. Special Diet	☐ Yes	☐ No
8.	Active Hepatitis	☐ Yes	☐ No	18. Intestinal Problems	☐ Yes	☐ No	28. Sleep Walking	☐ Yes	☐ No
9.	Seizure Disorder	☐ Yes	☐ No	19. Bladder Infection	☐ Yes	☐ No	29. Eating Disorder	☐ Yes	☐ No
10.	Bleeding disorder	☐ Yes	☐ No	20. Skin Problem	☐ Yes	☐ No	30. Other:		

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/condition occurs ☐ How you care for symptom/condition
☐ How symptom/condition restricts applicant's activity in any way, including applicant's ability to hike

Item No.	Detailed Description (including restrictions if any)

Mental Health History

NatureBridge requires that any student with a history of counseling that requires medication, hospitalization, or residential treatment exhibit one year of stability before they will be accepted for a program.

Has the applicant had treatment, counseling, or hospitalization with a mental health professional? YES NO

Is he/she currently receiving treatment or counseling services? YES NO

Please circle any of the applicable causes for treatment or counseling:

Suicide Attempts or Ideation
Substance Abuse
Eating Disorder
Depression
Family Issues
Other_____

Please provide specific dates and details of counseling history and medications prescribed:

_____

_____

_____

Please provide contact information of counseling therapist:

_____ _____

Name Phone

B. Allergies (Including Medicines, Foods, Bites and Stings) list below **None** ☐

Allergy – list below	Reaction	Medication Required

C. Medications (list any medication you are using, including psychiatric and over the counter medication below) None ☐

Medication	Condition	Dosage (size & freq.)	Current Side effects

D. Required Immunization

Immunization	Requirement	Year of Last Immunization
Tetanus	Within 10 years of program start	

E. Hospitalization/Emergencies

Please list any hospital or emergency department visits in the last two years. **None** ☐

Dates	Reason	Length of Stay

F. Current Exercise Activity

Note: You will be hiking a good portion of the time. In order to insure you have the highest quality experience we encourage you to physically prepare yourself.

Current Exercise Activity	Frequency	Leisurely	Moderately	Intensely

G. Additional Participant Comments or important information we should know

_____

_____

_____

_____

****Any Dietary Needs** (Vegetarian, only eat fish, no eggs, etc)? _____

Physician's Signature Required

How long have you known the applicant? _____

Name of examining Physician (please print): _____

Address: _____

Telephone: (_____)_____ Fax (_____)_____

Physician's Signature _____ Date _____

DRM 12/09