WILD ROCKIES FIELD INSTITUTE

Medical Form

TO BE FILLED OUT BY THE STUDENT APPLICANT

Student name:_____ Course: _____

Birthdate: _____ Gender: _____

Temporary phone: _____ Permanent phone: _____

Medical Insurance (Participants must have insurance during course.)

Provider:_____ Policy number: _____

Emergency Contact

Name:_____ Relationship: _____

Address and email:_____

Day phone:_____ Evening phone: _____

Student applicant must SIGN the last page.

Information entered on this form **MUST be COMPLETE and ACCURATE** so that WRFI can support you on the course. Incomplete medical information may result in disenrollment without refund or credit.

WRFI COURSE INFORMATION TO BE READ BY THE MEDICAL PROFESSIONAL

Wild Rockies Field Institute (WRFI) courses are wilderness expeditions, varying in length from seven days to nine weeks. WRFI operates in remote areas where evacuation to medical facilities can take 1-3 days.

- **Weather conditions** can be extreme with temperatures ranging from -20°F. to +100°F. Prolonged storms, high winds, intense sunlight, sudden immersion in cold water and/or high seas are possible.
- Depending on the specific type of course, **physical demands** can include: carrying a pack of 45-75 pounds on uneven terrain at altitudes up to 12,000 feet; paddling heavily loaded kayaks or canoes; or cycling up to 60 miles in a day.
- While participating in a WRFI course, this student will; sleep outdoors, experience long travel days, participate in physical work projects, and participate in upper-level academic studies.
- WRFI is *NOT* a rehabilitation program. WRFI is not the place to quit drinking or drugs or to deal with behavioral or psychological problems.
- Physical ability to complete these activities safely is necessary for the student to participate in our courses.

In the interest of the personal safety of both the applicant the other course members, please consider the above description carefully when completing the Medical Form. A "yes" answer does not automatically cancel a student's enrollment. If we have any question on the student's capacity to successfully complete the course we will call you to discuss it. (The medical professional completing this form may not be a relative of the applicant.)

The student will not be accepted on the course until the Medical Form has been returned, reviewed and approved by WRFI staff. Your detailed comments will expedite our review of this form.

I have read and understand these aspects of WRFI courses. Medical Professional Initials:_____

Thank you!
-The Wild Rockies Field Institute

TO BE FILLED OUT BY A PHYSICIAN, F.N.P. OR P.A.

- Each question must be answered.
- **Please provide date and details for all "yes" answers.**

GENERAL MEDICAL HISTORY: Does the applicant currently have or have a history of:

1. Respiratory problems, including asthma? Yes No

If yes on question 1:

1a. Examiner's specific comments:_____

_____

1b. **If Asthma**, Last episode? Ever hospitalized? What triggers an attack?

_____

1c. Is the asthma controlled with an inhaler? Yes No N/A

If yes: please have the student bring one or more metered dose inhalers (MSI) with them for their course; an aerochamber/spacer is recommended.

2. Gastrointestinal disturbance? Yes No
3. Diabetes? Yes No
4. Bleeding, DVT (deep vein thrombosis), or blood disorders? Yes No
5. Hepatitis or other liver disease? Yes No
6. Neurological problems? Epilepsy? Yes No
7. Seizures? Yes No
8. Dizziness or fainting episodes? Yes No
9. Migraines? Yes No
10. Hypertension? Yes No
11. Disorders of the urinary or reproductive tract? Yes No
12. Cardiac problems? Unexplained chest pains? Yes No
13. Vision problems? Yes No
14. Hearing problems? Yes No

If yes on questions 2-14: Describe frequency, date of last episode, severity, and comments.

_____

_____

_____

15. Any other disease?_____
16. Does this person see a Medical or Physical specialist of any kind? Yes No

If yes on question 16:

Please provide name/address:_____

Please specify the issue(s):_____

For FEMALE STUDENTS, please answer questions 17 and 18:

17. Treatment or medication for menstrual cramps? Yes No
18. Is she pregnant? Yes No

If yes on questions 17-18, please comment:

_____

_____

MUSCLE/SKELETAL INJURIES/FRACTURES: Does the applicant currently have or does he/she have a history of:

19. Knee, hip or ankle injuries (including sprains) and/or surgery? Yes No

If yes on question 19:

19a. Type of injury or surgery: _____

19b. When did the surgery occur?: _____

19c. Is there full ROM? Full strength? Yes No

19d. What is the most rigorous activity participated in since the injury/surgery? Results?

_____

19e. Date of last occurrence and the effect of the problem on current activity level):

_____

_____

_____

20. Shoulder, arm or back injuries (including sprains) and/or surgery? Yes No

If yes on question 20:

20a. Type of surgery: _____

20b. When did the surgery occur? _____

20c. Is there full ROM? Full strength? Yes No

20d. What is the most rigorous activity participated in since the injury/surgery? Results?

_____

20e. Date of last occurrence and the effect of the problem on current activity level:

_____

_____

_____

21. Any other joint problems? Yes No

If yes on question 21: Include date of last occurrence and the effect of the problem on current activity level:

_____

22. Head injury? Loss of consciousness? For how long? Yes No

If yes on question 22: Include date of last occurrence and the effect of the problem on current activity level:

_____

_____

_____

PERSONAL HISTORY (COUNSELING/PSYCHIATRIC/LEARNING DISABILITIES)

23. Has he/she had treatment or counseling with a mental health professional? Yes No

If yes on question 23:

23a. Reason for treatment or counseling?

_____ suicide gesture
_____ family issue/divorce
_____ eating disorder (anorexia/bulimia)
_____ depression/anxiety
_____ other
_____ academic/career
_____ substance abuse/chemical dependency
_____ learning disability (provide specifics below)
_____ ADD/ADHD

23b. Has she/he ever been hospitalized for mental health reasons? Yes No

23c. Please provide **specific dates** and details of counseling, hospitalization, Hx, and medications prescribed:

_____

_____

23d. Is he/she currently in treatment or counseling? Yes No

If yes on question 23d: please provide therapist name:_____

Address: _____

Phone number: (_____) _____

24. Does the applicant have a learning disability or other physical, cognitive, sensory, or emotional condition that would require a special learning environment or accommodation? Yes No

If yes on question 24: Describe how the condition affects the participant and typical accommodations:

_____

_____

ALLERGIES

25. WRFI often disinfects water with iodine or chlorine. Is this contraindicated? Yes No

26. Is he/she allergic to any foods? Are there any dietary restrictions? Yes No

27. Allergic to insect bites or bee stings? Yes No

28. Any other allergies?_____

29. History of anaphylaxis? Yes No

If yes on question 25-29, please comment:

_____

_____

If appropriate, please have the student bring a personal supply of epinephrine, preferably a pre-loaded auto-injector, and know how to use it.

MEDICATIONS

30. Is he/she allergic to any medications? Yes No

If yes on question 30, please list:

_____

_____

31. Is he/she currently taking any medications? Yes No

If yes on question 31, please list:

Medication Dosage (amt./freq.) Side Effects/Restrictions For what conditions?

_____

_____

COLD, HEAT, ALTITUDE

32. History of frostbite or Raynaud's Syndrome? Yes No

33. History of acute mountain sickness, high altitude pulmonary/cerebral edema? Yes No

34. History of heat stroke or other heat related illness? Yes No

If yes on questions 32-34, please comment: _____

FITNESS

35. 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

Activity: _____ Frequency: _____

Duration/Distance: _____ Intensity Level: Easy Moderate Competitive

36. Is this person overweight or underweight? Yes No

If yes on question 36, how much? _____

37. Does this person smoke? Yes No

If yes on question 37, how much? _____

38. Swimming ability (check one): _____Non-swimmer _____Recreational _____Competitive

PHYSICAL EXAMINATION

Physician must read and fill out pages 1-5. **Physical examination data cannot be more than a year old from the starting date of the WRFI course.**

WRFI requires a tetanus immunization within 10 years of the start date of the course. Courses outside the U.S. may require additional immunizations.

_____	_____	_____ /_____ /_____	_____	_____
Blood Pressure	Pulse	Last Tetanus Inoculation	Height	Weight

39. On the basis of the background information at the beginning of this form and your examination, do you feel that this individual can participate in a WRFI course?

Yes No

General Impressions and Comments. Please explain answer to above question if answered, "No":

_____

_____

_____

EXAMINER'S NAME (Please print legibly): _____

Address: _____ **Phone:** _____

PHYSICIAN, F.N.P. OR P.A. SIGNATURE: _____ **Date:** _____

*****Student Applicant Signature Required:**

The information I have entered on this medical form is accurate and complete. Wild Rockies Field Institute (WRFI) has my permission to provide me with or transport me to emergency medical care, including: anesthesia, operation, hospitalization, or other treatments (whether for an emergency or not) should these become necessary. I agree to be responsible for any and all costs associated with such treatment, including the costs of evacuation. All my information will be kept confidential by WRFI staff, except that information may be disclosed to medical or emergency personnel as needed for my care. If WRFI arranges for treatment for me by a medical provider, I authorize that medical provider to release information about me and my condition and treatment to WRFI.

Many students with serious medical and psychological issues have completed WRFI courses. I understand that WRFI must be aware of these conditions and that failure to disclose such information could result in serious harm. I understand that I will be in remote areas, hours or days away from medical facilities and where communication, transportation, or evacuation may be delayed. If I arrive at the course start with a medical, behavioral, or psychological condition which is not indicated on my medical form, I understand that I may be removed from the course, charged an evacuation fee, and will not receive a refund of tuition or academic credit.

_____ _____

*****Applicant Signature** **Date**

PLEASE RETURN ALL 6 PAGES TO: wrfi@wrfi.net

OR MAIL TO:

Wild Rockies Field Institute
P.O. BOX 7071
MISSOULA, MT 59807

For questions, please contact the WRFI office at: (406) 549-4336 or email **wrfi@wrfi.net.**