MEDICAL RECORD

PART I - GENERAL INFORMATION

SCHOOL NAME: ____________ START DATE: _________

APPLICANT

Name ______________________________
Gender ❑Male ❑Female
Age at Course Start _____DOB ___________
Height ______ft._______in.
Weight________lbs.
Occupation __________________________
E-mail Address ______________________

Address ______________________Apt. #___
City/State/Zip _________________________
____
Day Telephone: _______________________
Evening Telephone: ____________________
Cell Telephone: _______________________
FAX: ______________________________

Please complete information within this box IF one or both of the following apply:

- **you are under 21 years of age**
- **your parent/guardian is your primary Emergency Contact**

Parent/Guardian: ______________________
Address: ____________________________
City/State/Zip: ________________________
Occupation/Title: ______________________
Day Phone: __________________________
Evening Phone: _______________________
Cell Phone: __________________________
E-mail address: _______________________
Parent/Guardian: ______________________
Address: ____________________________
City/State/Zip: ________________________
Occupation/Title: ______________________
Day Phone: __________________________
Evening Phone: _______________________
Cell Phone: __________________________
E-mail address: _______________________

EMERGENCY CONTACT

(other than parent/guardian)

Name:
Relationship:
Day Telephone:
Evening Telephone:
Cell Telephone:

FAMILY PHYSICIAN

Name:
Telephone:
FAX:

Do you speak/understand English? ❑**Yes** ❑**No**

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ETHNIC BACKGROUND (OPTIONAL)

❑Asian ❑Caucasian ❑American Indian or Alaskan Native ❑Hispanic or Latino
❑Multiethnic ❑Native Hawaiian or Pacific Islander ❑African American ❑Unknown
❑Other ____________________

SIGNATURE REQUIRED - Consent is hereby given for the applicant to attend an EVERGLADES AREA TOURS program and permission is given for any emergency anesthesia, operation, hospitalization or other treatment (whether for an emergency or not) which might become necessary. I agree to be responsible for any and all costs associated with such treatment, including the costs of evacuation, if any. All information will be kept confidential except that information may be disclosed to any medical or other provider as needed for my (or my child's) care. If Everglades Area Tours arranges for treatment for me (or my child) by a medical provider, I authorize that medical provider to release information about me (or my child), and my (or my child's) condition and treatment to Everglades Area Tours. Over the years, many students with a variety of medical and psychological difficulties have successfully completed our programs, but we must be aware of these conditions. **Failure to disclose such information could result in serious harm to you (or your child) and fellow students. I understand that I (or my child) may be in remote areas, several hours or days away from any medical facility or where communication, transportation, or evacuation is subject to delay.** If you (or your child) arrive at the program start with a pre-existing medical, behavioral or psychological condition which is not indicated on your medical form and you are subsequently unable to participate fully or are forced to leave the program because of that condition, you will forfeit tuition and may be charged an evacuation fee.

Parent/Guardian Signature (if the applicant is under legal age) ____ **Date** ____________

Applicant Signature ____ **Date** ____________

PART II - APPLICANT HISTORY: PAST AND PRESENT MEDICAL PROBLEMS

A. CONDITIONS AND SYMPTOMS (FILL IN EVERY BLANK)

1. High Blood Pressure ❑ ❑
2. Heart Disease ❑ ❑
3. Heart Murmur ❑ ❑
4. Irregular Heartbeat ❑ ❑
5. Family history of Heart attack ❑ ❑
6. Tuberculosis ❑ ❑
7. Recent exposure to TB ❑ ❑
8. Positive TB test ❑ ❑
9. Active Hepatitis ❑ ❑
10. History of Hepatitis ❑ ❑
11. Seizure Disorder/Epilepsy ❑ ❑
12. Seizure within the past year ❑ ❑
13. Bleeding Disorder ❑ ❑
14. Blood disorder/anemia sickle cell trait ❑ ❑
15. Chronic Cough ❑ ❑
16. Recurrent Lung Infections ❑ ❑
17. Asthma ❑ ❑
18. Diabetes ❑ ❑
19. Hypoglycemia (low blood sugar) ❑ ❑
20. Anorexia Nervosa ❑ ❑
21. Bulimia ❑ ❑
22. Cancer ❑ ❑
23. Skin Problem ❑ ❑
24. Frostbite ❑ ❑
25. Circulation Problems ❑ ❑
26. Bed-Wetting ❑ ❑
27. Headaches ❑ ❑
28. Head injury w/ neurological impairment ❑ ❑
29. Stomach Ulcers ❑ ❑
30. Intestinal Problems ❑ ❑
31. Heatstroke ❑ ❑
32. Bladder Infection ❑ ❑
33. Difficulty Urinating ❑ ❑
34. Kidney Problems ❑ ❑
35. Thyroid Problems ❑ ❑
36. Endocrine Problems ❑ ❑
37. Hearing Impairment ❑ ❑
38. Vision Impairment ❑ ❑
39. Motion Sickness ❑ ❑
40. Sleep Walking ❑ ❑
41. Broken Bones ❑ ❑
42. Neck Problem ❑ ❑
43. Back Problem ❑ ❑
44. Elbow/Wrist/Hand Problem ❑ ❑
45. Shoulder Problem ❑ ❑
46. Knee Problem ❑ ❑
47. Ankle Problem ❑ ❑
48. Leg/Hip Problem ❑ ❑
49. Foot Problem ❑ ❑
50. Currently Pregnant ❑ ❑
51. Medical Equipment Devices ❑ ❑
52. Learning Disability ❑ ❑
53. Special Diet ❑ ❑
54. Unexplained Weight Loss ❑ ❑
55. Altitude Problem ❑ ❑
56. ADD/ADHD ❑ ❑
57. Food Allergies ❑ ❑

Do you currently or regularly have any of the following symptoms?

58. Chest Pain/Pressure ❑ ❑
59. Heart Palpitations ❑ ❑
60. Frequent shortness of breath ❑ ❑
61. Unexplained Sweating ❑ ❑
62. Frequent Dizziness ❑ ❑
63. Frequent Fainting ❑ ❑
64. Heartburn ❑ ❑
65. Muscle Cramps ❑ ❑
66. Intolerance to warm temps ❑ ❑
67. Intolerance to cold temps ❑ ❑
68. PMS or menstrual cramps ❑ ❑
69. Other ❑ ❑

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE ITEMS, PLEASE EXPLAIN BELOW. INCLUDE THE FOLLOWING:

- What specific symptoms are occurring
- How often symptom/condition occurs
- Date of last occurrence
- How long symptom/condition lasts
- How you care for symptom/condition
- How symptom/condition restricts Your activity in any way, including your ability to run, lift, climb or carry

ITEM #	DETAILED DESCRIPTION (INCLUDE RESTRICTIONS IF ANY)

PART II- APPLICANT HISTORY:
PAST AND PRESENT MEDICAL PROBLEMS, CONTINUED

B. ALLERGIES (INCLUDE ALLERGIES TO MEDICINES, FOODS AND INSECT BITES/STINGS)

NONE ❑ OR...

ALLERGY (List Below)
REACTION
MEDICATION REQUIRED (If Any)

ALLERGY (List Below)	REACTION	MEDICATION REQUIRED (If Any)

C. MEDICATIONS YOU ARE CURRENTLY TAKING –

(If psychiatric medication, list any taken within the past two months)

NONE ❑ OR... List any medications you are using, including psychiatric, over-the-counter, inhalers or herbal supplements.

MEDICATION	CONDITION/SYMPTOM	DOSAGE/ FREQUENCY	DATE STARTED	SIDE EFFECTS

NOTE: If you are taking prescription medication(s), bring double your normal dosage in separate, non-breakable, waterproof containers along with dosage .instructions. All medication(s) listed MUST accompany student on course.

D. IMMUNIZATIONS – Everglades Area Tours recommends that all of its participants have a current tetanus immunization. Tetanus booster must be within ten years of course start date.

E. HOSPITALIZATIONS/EMERGENCIESIURGENT CARE

NONE ❑ OR... List any hospital, emergency department or urgent care visits within the past two years.

DATE OF VISIT/ADMISSION	REASON	LENGTH OF STAY

F. CURRENT EXERCISE ACTIVITY (It is important for us to be aware of your fitness level.)

List the activities you engage in daily or weekly which indicate your current fitness level. Include activities such as walking a pet, mowing the lawn, or after-school activities like playing basketball or skateboarding.

ACTIVITY	HOW OFTEN	DURATION	DISTANCE	INTENSITY
				❑Low ❑Moderate ❑High
				❑Low ❑Moderate ❑High
				❑Low ❑Moderate ❑High

NOTE: You will be expected to engage in rigorous physical activity during your Everglades Area Tours experience. It is vital that you start (or continue) a conditioning regimen in preparation for your course.

G. SWIMMING ABILITY - (CHECK ONE)

❑ Non Swimmer
❑ Cannot Swim more than 100 yards
❑ Moderate Swimmer
❑ Strong Swimmer
❑ Current Life Saving Certificate

H. BLOOD PRESSURE - (MUST BE TAKEN WITHIN SIX (6) MONTHS OF COURSE START)

Blood Pressure_______/_______
Date Taken _______/______/_______

If BP is over 150/90, please take a second reading
Second Reading ________/_________
Date Taken _______/______/_______

NOTE: BLOOD PRESSURE MAY BE TAKEN WITH APPARATUS AT A LOCAL DEPARTMENT OR DRUG STORE

PART II - APPLICANT HISTORY: PAST AND PRESENT MEDICAL PROBLEMS, CONTINUED

I. PERSONAL HISTORY - COUNSELING HISTORY (BASED ON PAST TWO YEARS)

Have you been diagnosed or treated for any of the following within the past 2 years?

Yes No
❑ ❑Attention Deficit Disorder
❑ ❑Adjustment Disorder
❑ ❑Anxiety Disorder
❑ ❑Disruptive Behavior Disorder
❑ ❑Impulse Control Disorder

Yes No
❑ ❑Learning Disorder
❑ ❑Developmentally Disabled
❑ ❑Mood Disorder
❑ ❑Personality Disorder

Yes No
❑ ❑Pervasive Developmental Disorder
❑ ❑Schizophrenia
❑ ❑Substance Related Disorder

Have you received treatment or therapy for any of the above conditions?

Yes No
❑ ❑Medication(s)
❑ ❑Outpatient Counseling
Yes No
❑ ❑Day Treatment
❑ ❑Residential Treatment
Yes No
❑ ❑Hospitalization

Are you currently (or within the past year) taking medication(s) to treat any mental health issue? ❑Yes ❑No

Have you experienced any of the following significant events within the past year? If "Yes", please explain.

Yes No
❑ ❑Serious Illness________________________________
❑ ❑Serious Accident/Injury________________________
❑ ❑Incarceration__________________________________
Yes No
❑ ❑Self Harm__________________________________
❑ ❑Expulsion__________________________________
❑ ❑Death of a friend or family member______________

Please arrange for a release of information with your therapist and/or prescribing physician so we may contact them for further information as part of this screening process. Have you done so? ❑Yes ❑No

Name of current or most recent therapist ________________
____
Telephone ____
Fax ____
E-mail Address ______________________________________
Name of current or most recent physician _______________
____
Telephone ____
Fax ____
E-mail Address ______________________________________

J. LIFESTYLE

ISSUE			***FURTHER INFORMATION***
Do you use alcohol?	❑Yes	❑No	Last Used? ______________________
Do you use tobacco?	❑Yes	❑No	Date(s) ______________________
Do you use drugs (other than alcohol Or prescription) on a regular basis?	❑Yes	❑No	Reason ______________________
Do you have a history or current problem With substance abuse or dependency?	❑Yes	❑No	
Have you been on probation or had any Involvement with the justice system?	❑Yes	❑No	

How Much? ______________ How often? ____________
How Much? ______________ How often? ____________
Which One(s)? _________________________________
How Often? ____________________________________
Substance(s) Used? _____________________________

PART III APPLICANT QUESTIONNAIRE

THE ANSWERS TO THESE QUESTIONS WILL HELP YOUR INSTRUCTORS PLAN YOUR COURSE ACTIVITIES AND LEARN MORE ABOUT YOU.

1. Why did you decide to attend an Everglades Area Tours expedition?

2. What are you looking forward to the most on your Everglades Area Tours course?

❑ Getting outside ❑ Meeting new people ❑ Making new friends
❑ Having a new experience ❑ Learning new skills ❑ Other

Additional comments:

3. What do you hope to learn or accomplish in the Everglades?

4. List 5 words you would use to describe yourself:

1.

2.

3.

4.

5.

5. What is the hardest thing you have ever done? How did you feel afterwards?

6. What concerns, if any, do you have about your Everglades Area Tours course?

PART IV INSURANCE INFORMATION

STAPLE OR TAPE A COPY OF THE FRONT & BACK OF YOUR HEALTH INSURANCE CARD IN THIS SPACE.

IF YOU DO NOT CARRY A HEALTH INSURANCE POLICY CHECK HERE: ❑

The following information is needed for our insurance records. Each applicant is responsible for any and all medical expenses and should be covered by his/her own sickness and accident insurance.

Insurance Company Name:_______________________ Policy Number:________________________

Claim Billing Address:__________________________ City/State/Zip:_________________________

Prescription Plan Name:_________________________ Policy Number:________________________

Claim Billing Address:__________________________ City/State/Zip:_________________________