

HEALTH FORM

SELF-REPORTING FORM



Name: _____ Course Title: _____

Temporary or Work Phone: (_____) _____ Height: _____ Weight: _____

Permanent Phone: (_____) _____ Sex: _____ Age: _____

As a student of the National Outdoor Leadership School (NOLS), your health history is important for your safety as well as other course members. Please carefully consider the specific description of the course you are applying for when completing this health form. For any “yes” answers please provide additional information. If we have questions we will discuss them with you prior to going into the field.

NOLS disinfects all wilderness water with chlorine, chlorine dioxide, or by boiling. Not all of these methods are effective against cryptosporidium. Immunocompromised people may wish to obtain an appropriate water filter.

PARTICIPANT: Please circle YES or NO for each item. Each question must be answered. **If you circle YES, please explain briefly in the space provided or attach an additional page.**

General Medical History

Do you currently have or do you have a history of:

1. Respiratory problems? Asthma? _____ 1. YES NO
Is the asthma well controlled with an inhaler? What triggers an attack? Last episode? Ever hospitalized?

2. Gastrointestinal disturbances? _____ 2. YES NO

3. Diabetes? _____ 3. YES NO

4. Bleeding or blood disorders? _____ 4. YES NO

5. Hepatitis or other liver disease? _____ 5. YES NO

6. Neurological problems? Epilepsy? _____ 6. YES NO

7. Seizures? _____ 7. YES NO

8. Dizziness/vertigo or fainting episodes? _____ 8. YES NO

9. Migraines? How frequent and are they debilitating? _____ 9. YES NO

10. Disorders of the urinary or reproductive tract? _____ 10. YES NO

11. Any other health complaint? _____ 11. YES NO

12. Do you see a medical/physical specialist of any kind? _____ 12. YES NO

13. Treatment for menstrual cramps? _____ 13. YES NO NA

14. Are you pregnant? _____ 14. YES NO NA

15. Do you have any history of cardiac illness or significant risk factors, such as known _____ 15. YES NO
coronary artery disease, hypertension, diabetes, hyperlipidemia, angina, tachycardia, bradycardia,
unexplained chest pain or immediate family history of early cardiac death?

Depending on your history, risk factors and age, a stress ECG or waiver from your cardiologist may be required.

Please comment: _____

16. Do you have a history of knee, hip, ankle, shoulder, arm or back injuries
(including sprains) and/or operations? _____ 16. YES NO

(Please explain:) _____

17. Head Injury? Loss of consciousness? For how long? _____ 17. YES NO

18. Do you have any physical, cognitive, sensory or emotional condition that would require special consideration? _____ 18. YES NO
19. Are you currently in, or have you had, psychotherapy with a mental health professional? _____ 19. YES NO
20. Do you have any history of substance abuse, depression, eating disorder or suicidal thoughts? _____ 20. YES NO
21. Do you have any allergies, e.g. insects, bees, medications, food, environmental, other? _____ 21. YES NO
- Please describe: _____

22. Do you have any dietary restrictions? _____ 22. YES NO
- Please describe: _____

23. Are you currently taking or have you been prescribed any medications in the past two years? (Please list below) _____ 23. YES NO

| Medication | For What Condition | Dosage (amt/frequency) | Side Effects/Restrictions |
|------------|--------------------|------------------------|---------------------------|
| | | | |
| | | | |

24. History of Frostbite or Acute Mountain Sickness? _____ 24. YES NO
25. History of heat stroke or other heat related illness? _____ 25. YES NO
26. Do you exercise regularly? _____ 26. YES NO

| Activity | Frequency | Duration/Distance | Intensity Level (Easy/Moderate/Competitive) |
|----------|-----------|-------------------|---|
| | | | |
| | | | |

27. Do you smoke? If so how much? _____ 27. YES NO
- 28 Swimming ability (CHECK ONE): _____ Non-swimmer _____ Recreational _____ Competitive _____

NOLS SUGGESTS A TETANUS IMMUNIZATION WITHIN 10 YEARS OF THE START DATE OF THE COURSE.

The information provided above is a complete and accurate statement of any physical and psychological conditions which may affect my participation in this trip. I realize that failure to disclose such information could result in serious harm to myself and fellow students. I agree to inform NOLS should there be any change in my health status prior to the start of the trip. On the basis of the background information at the beginning of this form, and what I know or suspect about my physical and psychological health, I am fully capable of participating in this NOLS trip.

Participant's Signature: _____ DATE: _____

Parent or Guardian signature required if participant is under age 18: _____

WORLD HEADQUARTERS
 284 LINCOLN ST.
 LANDER, WY
 82520, USA
 1.800.710.6657
 NOLS.EDU

WORLDWIDE LOCATIONS
 ALASKA / AUSTRALIA / EAST AFRICA / INDIA / MEXICO / NEW ZEALAND /
 NORTHEAST / PACIFIC NORTHWEST / PATAGONIA / RIVER BASE /
 ROCKY MOUNTAIN / SCANDINAVIA / SOUTHWEST / TETON VALLEY /
 THREE PEAKS RANCH / WYSS CAMPUS / YUKON