



**NAROPA UNIVERSITY**  
**Wilderness Therapy**  
**Confidential Medical Record**

WT Program Notes
Follow-up

**TO ALL PROSPECTIVE AND CURRENT STUDENTS:** Filling out this medical form honestly and completely is the first step in taking care of yourself. For your safety, it is important that we know as much as we can about your physical condition. Many medical conditions will not prevent you from successfully completing the program, but failure to disclose information could result in serious harm to yourself or other participants. Every item on this form must be completed. If it does not apply to you, mark "N/A". If you have certain medical conditions, we may require that you have a physician fill out a supplemental form. All information you provide will be shared only with the Wilderness Therapy faculty or staff members working with you in the field.

**PART I. General Information**

<b>Name</b>	_____	<b>Birth Date</b>	_____	<b>Age</b>	_____
<b>Address</b>	_____	<b>City/State/ZIP</b>	_____		
<b>Phone</b>	( ) _____	<b>Email</b>	_____		
<b>Evening Phone</b>	( ) _____	<b>Height</b>	_____	<b>Weight</b>	_____ <b>Lbs.</b>
<b>Emergency Contact Name</b>	_____	<b>Phone</b>	( ) _____		
<b>Phone</b>	( ) _____	<b>FAX</b>	( ) _____		
<b>Family Physician</b>	_____	<b>Phone</b>	( ) _____		
<b>Physician Address</b>	_____				
<b>Insurance Company</b>	_____				
<b>Policy Number</b>	_____				

**PART II. Medical Information\***

**Allergies:** (Include Medicines, Foods, Bites, and Stings)  None

Allergy-List Below	Reaction	Medication Required

**Medications:** List any medications you are taking, including psychiatric and over-the-counter medications.  None

Medication	Condition	Dosage (Amt. and Freq.)	Current Side Effects

**Current Exercise and Fitness Level:** Please list your current exercise activity.

Activity	Frequency	Approx. Time/Distance	Leisurely	Moderate	Intensely

\*Attach additional pages if necessary.

### PART III. Health Profile

- |   |   |
|---|---|
| <p>1. Smoker _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Pregnant _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Seizure _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Family history of heart attack _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Hospitalization within past 2 years _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>6. Emergency Dept. visit within past year _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Other medical illnesses/symptoms/requirements _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Medical Equipment _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Neck/back/shoulder/knee/ankle pain, injury or persistent limb problems _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|---|---|

Issue No.	Detail Description (including symptoms/any restrictions. Use additional pages if necessary.)

#### Blood Pressure (Measured within 6 months.)

Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Date taken \_\_\_\_\_

### PART IV. Do I Need A Physical Examination?

Please complete the following section carefully. **If you check “yes” to any of the questions below, you are required** to have a Physician, Physician’s Assistant, or Nurse Practitioner fill out a Physician Examination form prior to participating in the program. The form may be completed based on an examination by a physician at any time during the past year. Naropa University reserves the right to require a physical examination upon review of participant history section of this form. The Physician Examination form is available from the Wilderness Therapy Admissions Coordinator or Trip Coordinator.

#### Health Problems. Do you have any of the following conditions?

- |                          |                          |   |
|--------------------------|--------------------------|---|
| yes                      | no                       |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Resting pulse reading over 100  |
| <input type="checkbox"/> | <input type="checkbox"/> | Systolic blood pressure reading over 150 and/or diastolic blood pressure reading over 90  |
| <input type="checkbox"/> | <input type="checkbox"/> | Experiencing chest pain and/or pressure   |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease past or present (including high blood pressure)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic illness or physical infirmity   |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes  |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure disorder (If “yes” your physician <i>must</i> provide a letter/note that states these seizures are adequately managed for an extended stay in the backcountry.)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting/Dizziness (unexplained and ongoing)  |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal heart murmur (if you have <u>normal</u> or <u>functional</u> murmur, written confirmation by your physician is required. <u>Only</u> if your murmur is <u>abnormal</u> , is a physician’s exam required. |
| <input type="checkbox"/> | <input type="checkbox"/> | I would prefer my physician’s advice prior to program participation.  |

Additional Comments \_\_\_\_\_

### PART V. Signature Required

I understand that the trips of the Wilderness Therapy MA Program are physically and mentally strenuous experiences that may take place in a remote wilderness area, far from conventional medical facilities, for a period of up to eight (8) days. The information on the preceding pages is a complete and accurate statement of my past and present medical condition, and I have included all physical and psychological factors that may affect my participation in these classes. I realize that failure to disclose such information could result in serious harm to myself and/or fellow participants. I agree to indemnify and hold Naropa University harmless if all relevant information is not disclosed. **I agree to notify the Wilderness Therapy Trip Coordinator should there be any change in my health status at any time during the program.**

\_\_\_\_\_  
Participant’s Signature

\_\_\_\_\_  
Date