WT Program Notes
Follow-up

NAROPA UNIVERSITY
Wilderness Therapy
Confidential Medical Record

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 your admissions counselor and the Wilderness Therapy faculty or staff members working with you in the field. It is your responsibility, in conjunction with your medical provider(s), to be aware of your own health, and to ensure your preparedness for every field section in the program. This includes providing whatever medications you require, as well as any medical information needed to ensure your safety and readiness.

PART I. General Information

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

PART II. Medical Information*

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

***If you have a history of anaphylaxis requiring epinephrine, you are required to bring TWO (2) epipens into each field section with you.**

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

	Yes	No
1. Smoker _____	❑	❑
2. Pregnant _____	❑	❑
3. Seizure _____	❑	❑
4. Family history of heart attack _____	❑	❑
5. Emergency Dept. visit within past year _____	❑	❑
6. Other medical illnesses/symptoms/requirements _____	❑	❑
7. Medical Equipment _____	❑	❑
8. Neck/back/shoulder/knee/ankle pain, injury or persistent limb problems _____	❑	❑
9. Hospitalization (medical or psychiatric) within past 2 years _____	❑	❑

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

Do you have any medical (physical or psychological) issues that might put you at risk in backcountry settings? _____
If yes, please describe: _____

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	
❑	❑	Resting pulse reading over 100
❑	❑	Systolic blood pressure reading over 150 and/or diastolic blood pressure reading over 90
❑	❑	Experiencing chest pain and/or pressure
❑	❑	Heart disease past or present (including high blood pressure)
❑	❑	Chronic illness or physical infirmity
❑	❑	Diabetes
❑	❑	Seizure disorder (If "yes" your physician *must* provide a letter/note that states these seizures are adequately managed for an extended stay in the backcountry.)
❑	❑	Fainting/Dizziness (unexplained and ongoing)
❑	❑	Abnormal heart murmur (if you have *normal* or *functional* murmur, written confirmation by your physician is required. *Only* if your murmur is *abnormal*, is a physician's exam required.
❑	❑	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 realize that failure to disclose such information could result in serious harm to myself and/or fellow participants, and may result in dismissal from the program." **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