



This High Adventure Medical Exam Form is required for Trail Life USA activities or events that exceed 72 hours in duration or include high altitude or high-exertion activities. A current completed Youth or Adult Participant Health and Medical Form MUST accompany this form.

HIGH ADVENTURE Medical Exam Form

Participant's Name Date of birth (MM/DD/YYYY) Age

Emergency Contacts:

Name Relationship

Home Phone # Cell Phone #

Name Relationship

Home Phone # Cell Phone #

Health Examination: To be completed by a Licensed Health Care Provider

Date of Exam: Vision Hearing
Height (inches): Weight (pounds): Normal Normal
Blood Pressure: Pulse: Glasses Contacts Abnormal

Table with 8 columns: Normal, Abnormal, Explain, if abnormal, Cardiovascular, Normal, Abnormal, Explain, if abnormal. Rows include Growth, development; Skin, glands, hair; Head, neck, thyroid; Eye, ears, nose; Teeth, tonsils; Respiratory; Other (specify).

COMMENTS

Dietary Restrictions

Approved for participation in: Hiking Competitive Sports Water Activities All Activities

Specific exceptions & recommendations (explain any restrictions OR limitations)

MEDICATIONS: To be completed by a Licensed Health Care Provider

List all medications currently prescribed. (If additional space is needed, please use the back of this page.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only. If none, please write "None" below.

Table with 4 columns: Medication, Strength, Frequency, Reason

The applicant will be participating in strenuous activity/activities that will include one or more of the following conditions: athletic competition, adventure challenge, or wilderness expedition (afloat or afoot) that may include high altitude, extreme weather conditions (including, but not limited to high humidity, heat and/or extreme cold), cold water, exposure, fatigue, and/or remote condition where readily available medical care cannot be assured. I hereby affirm that upon my examination and the information provided to me by the participant, there are no restrictions or limitations to his participation in the fore stated strenuous activity/activities.

Signature Licensed Health Care Provider Date

Print Name of Licensed Provider Phone

Address

City, State, Zip

This High Adventure Medical Exam Form is good for one year from the date of the exam by a Licensed Health Care Provider.

