Health Form

All CHILKAT GUIDES guests must have this form filled out by your physician, F.N.P., or P.A. in order to participate in one of our trips.

Guest's Name _____ Trip Name _____

(___)_____ (___)_____
Daytime or Temporary Phone (circle one) Permanent Phone

Gender Age Date _____

CHILKAT GUIDES Expedition Information for the Medical Professional
Chilkat Guides, Ltd. trips are wilderness expeditions, varying in length from five days to 2 weeks. CHILKAT GUIDES expeditions operate in remote areas where evacuation to modern medical facilities may take days.

Weather conditions can be extreme with temperatures ranging from 0 F to +90 F. Prolonged storms, high winds, intense sunlight, and/or sudden immersion in cold are possible.

While participating on a CHILKAT GUIDES expedition, guests will sleep outdoors, be outside in the elements for the duration of the expedition, and be on the river and hike in the surrounding mountains. Each participant is expected to take good care of him or herself.

In the interest of the personal safety of both the participant and the other expedition members, please consider the questions carefully when completing the health form. A "Yes" answer does not automatically cancel a guest's enrollment. If we have any questions on the guest's capacity to successfully complete the trip we will call the guest to discuss it.

All guests are REQUIRED to bring the following medications:
1 course of broad-spectrum antibiotics that is effective for upper respiratory problems.
1 course of broad-spectrum antibiotics that is effective for GI problems.

Physician, F.N.P. or P.A.:
Please check YES or NO for each item. Each question must be answered and please **provide date and details for all "yes" answers.**

General Medical History
Does this person currently have a history of:
1. Respiratory problems? Asthma? YES NO
Is the asthma well controlled with an inhaler? YES NO
If so, please have the guest bring inhaler(s) with them for their trip.
What triggers an attack? Last episode? Ever hospitalized? _____

2. Gastrointestinal disturbances? YES NO
3. Diabetes? YES NO
Examiner's specific comments: _____

4. Bleeding, DVT (deep vein thrombosis) or blood disorders? YES NO
5. Hepatitis or other liver disease? YES NO
Examiner's specific comments:

6. Neurological problems? Epilepsy? YES NO
7. Seizures? YES NO
8. Dizziness or fainting episodes? YES NO
9. Migraines? Medications, frequency, are they debilitating? YES NO
6-9. Describe frequency, date of last episode, and severity. ?

10. Disorders of the urinary or reproductive tract? YES NO
11. Any disease? YES NO
12. Does this person see a medical or physical specialist of any kind? YES NO
IF "yes" please specify the issue(s) and provide name/address of specialist.

Questions 13 and 14 are for Female Guests Only:

13. Treatment or medication for menstrual cramps? YES NO
14. Is she pregnant? YES NO
Examiner's specific comments:

15. Hypertension? YES NO
16. Cardiac problems? Unexplained chest pain? YES NO
Examiner's specific comments:

Cardiac Screening:

A stress ECG is recommended if the applicant is:	C**ardiac Risk Factors**
1. Over 35 years old and has 2 cardiac risk factors. 2. Over 50 years old and has 1 cardiac risk factor. 3. Over 50 years old and leads a sedentary lifestyle. 4. Any age with a known heart condition.	• High blood pressure • Diabetes • Current or prior cardiovascular disease • High blood cholesterol

Please provide a written note from your doctor stating the date of the stress ECG and the results	• Family history of heart disease (family member who's had a heart attack at less than 55 years of age.) • Smoking

The stress ECG requirement may be waived for applicants who are over 50 years of age with no cardiac risk factors and who are in good physical condition. **Their physician must note that the participant has a) no cardiac risk factors and b) excellent cardiac health on page 6 of this form.**

Muscle/Skeletal Injuries/Fractures

Does this person currently have or does he/she have a history within the past 3 years of:

17. Knee, hip or ankle injuries (including sprains) and/or surgery? YES NO

Type of injury or surgery? When did the injury or surgery occur?_____

_____

_____

_____

Is there full ROM? Full Strength? YES NO

What is the most rigorous activity participated in since the injury/surgery. Results? _____

_____

_____

Examiner's specific comments: (include date of last occurrence and the effect of the problem on current activity level) _____

_____

18. Shoulder, arm or back injuries (including sprains) and/or surgery? YES NO

Type of injury or surgery? When did the injury or surgery occur? _____

_____

_____

Is there full ROM? Full Strength? YES NO

What is the most rigorous activity participated in since the injury/surgery. Results?_____

_____

Examiner's specific comments: (include date of last occurrence and the effect of the problem on current activity level): _____

_____

19. Any other joint problems?

Examiner's specific comments: (include date of last occurrence and the effect of the problem on current activity level): _____

_____

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

Examiner's specific comments: (include date of last occurrence and the effect of the problem on current activity level): _____

_____

21. Does this person have any physical, cognitive, sensory, or emotional condition that would require a special teaching environment? YES NO
If yes, please describe how the condition effects you:

Allergies

22. Is he/she allergic to any foods? YES NO
Describe:

23. Are there any dietary restrictions? Please specify YES NO
vegetarian vegan other

24. Allergic to insect bites or bee stings? YES NO
If appropriate please bring 2-3 Epi Pens or Twinjects.
Examiner's specific comments:

25. Any other allergies? YES NO
Examiners Specific comments:

26. Water may be disinfected with iodine. Is iodine contraindicated? YES NO

Medications

27. Is he/she allergic to any medications? YES NO
If yes, please list:

28. Does this person plan to take any prescription or non-prescription medications on the trip? YES NO

CHILKAT GUIDES trips travel in remote areas where access to medical care may be one or more days away. The guest must understand the use of any prescription medications they may be taking. Written specific instructions are necessary. All guests who are required by their personal physician, psychiatrist or health care provider to take prescription medications on a regular basis must be able to do so on their own and without additional supervision.

Medication Dosage Side Effects/Restrictions Prescribed by? For what Conditions?

If Medication or Condition Changes Prior to Trip Start, Please inform CHILKAT GUIDES.

Field staff may administer the following over the counter medications at the appropriate dosage if a guest indicates the need for a particular medication (other medications may apply as appropriate). Please indicate if guest has any allergies or contraindications to the following medications.
Aspirin, Acetominophen, Ibuprofen, Psuedoephedrine, Diphenhydramine, Pepto Bismol, Imodium, Tolnaftate (external only)
Monistat-1, Orobase, Cavit, Activated Charcoal

_____

_____

Field staff may administer the following prescription medications and their appropriate dosage if a guest indicates the need for a particular medication (other medications may apply as appropriate). Administration of these medications will be checked off by the CHILKAT GUIDES medical director. Please indicate if the guest has any allergies or contraindications to the following medications.

Ciproflaxin , Azythromax, Ultram.

_____

_____

Fitness (please provide details concerning the participants exercise regime)
36. Does the applicant exercise regularly? YES NO
Activity _____ Frequency _____
_____ Duration/Distance _____ Intensity Level: Easy Moderate Competitive
Activity _____ Frequency _____
_____ Duration/Distance _____ Intensity Level: Easy Moderate Competitive

37. Is this person overweight? Underweight? If so how much? _____ YES NO

38. Swimming ability (CHECK ONE): Non-swimmer Recreational Competitive

Physical examination
Physician must read and fill out pages 1-6**. Physical examination data cannot be more than a year old from the starting date of the CHILKAT GUIDES trip.** (Please type or print legibly)

CHILKAT GUIDES Requires a Tetanus Immunization Within 10 Years of the Start Date of the trip. Exceptions Outside the U.S. May Require Additional Immunizations. Please refer to your trip description for specific information.

_____	_____	_____	_____	_____
Blood Pressure	Pulse	Last Tetanus Inoculation	Height	Weight

General Appearance, Impressions and Comments: (If applicable, address cardiac health. See Question #16.):
_____
_____
_____

Examiner's Name ( ) Phone

Street Address State Zip

Physician, F.N.P. or P.A. Signature Date

By my signature, I attest that the information in this form is correct and the person named on page one of this form is medically cleared to participate on an CHILKAT GUIDES trip based on the expedition information provided on page 1 of this form along with the background information provided by this person and my physical examination of him/her. Additionally, I have reviewed the medications that CHILKAT GUIDES carries in the field and noted any exceptions.