



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

**The applicant is not accepted on the course until the health form has been reviewed and approved by NOLS admissions personnel.**

*Your detailed comments will expedite our review of this form.*

**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 the applicant currently have or 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 student bring inhaler(s) with them for their course.**

What triggers an attack? Last episode? Ever hospitalized? \_\_\_\_\_

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2. Gastrointestinal disturbances?  YES  NO  
3. Diabetes?  YES  NO

Examiner's specific comments: \_\_\_\_\_

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4. Bleeding, DVT (deep vein thrombosis) or blood disorders?  YES  NO  
5. Hepatitis or other liver disease?  YES  NO

Examiner's specific comments: \_\_\_\_\_

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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. ? \_\_\_\_\_

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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. \_\_\_\_\_

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**Questions 13 and 14 Are For Female Students 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 required if the applicant is:	Cardiac 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.	<ul style="list-style-type: none"> <li>• High blood pressure</li> <li>• Diabetes</li> <li>• Current or prior cardiovascular disease</li> <li>• High blood cholesterol</li> <li>• Family history of heart disease (family member who's had a heart attack at less than 55 years of age).</li> <li>• Smoking</li> </ul>
Please provide a written note from your doctor stating the date of the stress ECG and the results.	

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 applicant has a) no cardiac risk factors and b) excellent cardiac health on page 6 of this form.**

**Muscle/Skeletal Injuries/Fractures**

Does the applicant 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?  YES  NO  
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 the applicant 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: \_\_\_\_\_  
\_\_\_\_\_

**Personal History(Counseling/Psychiatric/Learning Disabilities)**

NOLS requires that any student with a counseling history demanding medication, hospitalization or residential treatment, display one year of stability before they will be accepted for a course. They must be successfully employed or in school.

22. Has he/she had treatment, counseling or hospitalization with a mental health professional?  YES  NO

23. Is he/she currently in treatment or counseling?  YES  NO

24. Reasons for treatment or counseling?  
 suicide  ADD/ADHD  
 substance abuse/chemical dependency  family issues/divorce  
 eating disorder (anorexia/bulimia)  depression  
 academic/career  other \_\_\_\_\_

Please Provide **Specific Dates** and Details of Counseling Hx and medications that were prescribed:  
\_\_\_\_\_  
\_\_\_\_\_

25. Name, address and telephone number of therapist?  
Name \_\_\_\_\_ Phone \_\_\_\_\_  
Street Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_



**Allergies**

26. Is he/she allergic to any foods?  YES  NO  
Describe: \_\_\_\_\_

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

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

29. Any other allergies?  YES  NO  
Examiners Specific Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

**Medications**

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

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

**NOLS courses travel in remote areas where access to medical care may be one or more days away. The student must understand the use of any prescription medications they may be taking. Written specific instructions are necessary. All Students 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 Course Start, Please Inform NOLS.**

**Cold, Heat, Altitude**

33. History of frostbite or Raynaud's Syndrome?  YES  NO  
34. History of acute mountain sickness, high altitude pulmonary /cerebral edema?  YES  NO

When did the illness occur? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

35. History of heat stroke or other heat related illness?  YES  NO  
Examiner's specific comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Fitness (please provide details concerning the students 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. Does this person smoke? If so how much?  YES  NO  
There is no smoking allowed on NOLS courses. We recommend that applicant quit now.

38. Is this person overweight? Underweight? If so, how much? \_\_\_\_\_  YES  NO

39. 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 NOLS course.** (Please type or print legibly)

**NOLS Requires a Tetanus Immunization Within 10 Years of the Start Date of the Course.**  
Expeditions Outside the U.S. May Require Additional Immunizations. Please refer to your course 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 a NOLS course based on the expedition information provided on page 1 of this form along with the background information provided by the applicant and my physical examination of him/her.**

**Please Return All Six Pages To: NOLS, 284 Lincoln St. Lander, WY 82520**

