

# HEALTH FORM



<b>For NOLS Office Use Only</b>	<input type="checkbox"/> Initial Review OK	<input type="checkbox"/> Detailed Review OK
<input type="checkbox"/> Check Further	Date ____/____/____	AO Initials _____

_____	_____	_____
Student's Name	Course Code	Application ID#
(_____)_____	(_____)_____	
Daytime or Temporary Phone (circle one)	Permanent Phone	
Sex _____	Age _____	NOLS Grad <input type="checkbox"/> Non-Grad <input type="checkbox"/>

## Information for the Medical Professional

Field courses offered by the National Outdoor Leadership School (NOLS), are wilderness expeditions operating in remote areas of the world where evacuation to modern medical facilities may take days. There is a detailed course description for every course found here: <http://www.nols.edu/courses/>

**Living conditions** While participating on a NOLS expedition, students will sleep outdoors, experience long and physically demanding days, set up their own camp and prepare their own meals. Weather conditions can be extreme depending on the course type. Each student is expected to take good care of him or herself. On some courses, students may have the option to fast.

**Physical demands** on the applicant are considerable. Backpacking courses require carrying a backpack that may weigh up to 60 pounds or more over rough and rugged mountainous terrain. Water-based courses require sitting and paddling continuously for long periods of time and walking on rugged shorelines while carrying heavy items.

**Water disinfection.** NOLS disinfects all wilderness water with chlorine, chlorine dioxide, or by boiling. Not all of these methods are effective against cryptosporidium. Immunocompromised people may wish to obtain an appropriate water filter for their course.

NOLS is not a rehabilitation program. NOLS is not the place to quit smoking, drinking, or drugs or to work through behavioral or psychological problems.

Prior physical conditioning and a positive attitude are a necessity. Students find a NOLS course to be an extremely demanding experience both physically and emotionally.

**Full Disclosure:** In the interest of the health and well-being of both the applicant and the other expedition members, please answer the questions honestly and completely 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. However, failure to disclose a health condition that becomes relevant while on your course may result in dismissal from NOLS.

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

Your detailed comments will expedite our review of this form.

**M.D., D.O., F.N.P., APRN 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 N/A  
**If so, please have the student bring one or more metered dose inhalers (MDI) with them for their course and an aerochamber/spacer is recommended.**  
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/vertigo 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 provide name/address and specify the issue(s):

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13. Treatment or medication for menstrual cramps?  YES  NO  N/A

14. Is the applicant pregnant?  YES  NO  N/A

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

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### Cardiac History

15. Any history of cardiac illness or significant risk factors, such as known coronary artery disease, hypertension, diabetes, hyperlipidemia, tachyarrhythmia, symptomatic bradycardia (syncope, dizziness), unexplained chest pain (especially with exercise) or immediate family history of early cardiac death (<50 years old)?  YES  NO

Depending on the applicant's history, risk factors and age, a stress ECG or waiver from their cardiologist may be required.

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

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### Muscle/Skeletal Injuries/Fractures

Does the applicant currently have or have a history within the past three years of:

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

• Type of injury or surgery? When did the injury or surgery occur? \_\_\_\_\_

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• Is there full ROM? Full Strength?  NO  YES

• What is the most rigorous activity participated in since the injury/surgery. Results? \_\_\_\_\_

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

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

• Type of injury or surgery? When did the injury or surgery occur? \_\_\_\_\_

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• Is there full ROM? Full Strength?  NO  YES

• What is the most rigorous activity participated in since the injury/surgery. Results? \_\_\_\_\_

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

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18. 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) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. 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) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

20. Does the applicant have any physical, cognitive, sensory, or emotional condition that would require consideration?  YES  NO  
If yes, please describe how the condition affects the applicant: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Mental Health

Students with a history of psychotherapy that required medication or has included hospitalization or residential treatment, need to be in a period of stability ranging from six months to two years, depending on the condition, before they will be accepted for a course. Applicants need to be gainfully occupied such as attending school or employed. NOLS is not appropriate for applicants just leaving residential treatment facilities.

21. Has the applicant had psychotherapy?  YES  NO

22. Is the applicant currently in treatment or psychotherapy?  YES  NO

23. Reason(s) for treatment or therapy?

- |   |   |
|---|---|
| <input type="checkbox"/> suicide (thoughts, ideation, attempt)  | <input type="checkbox"/> ADD/ADHD         |
| <input type="checkbox"/> substance use disorder (drugs/alcohol) | <input type="checkbox"/> anxiety          |
| <input type="checkbox"/> eating disorder (anorexia/bulimia)     | <input type="checkbox"/> depression       |
| <input type="checkbox"/> obsessive-compulsive disorder          | <input type="checkbox"/> bipolar disorder |
| <input type="checkbox"/> academic/career/family issues          | <input type="checkbox"/> other _____      |

Please Provide **Specific** Details of psychotherapy and dates medications were prescribed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

24. Name and telephone number of psychotherapist?

\_\_\_\_\_  
Name (\_\_\_\_\_) \_\_\_\_\_  
Phone

## Allergies

Regardless of the allergen, individuals with a history of severe allergic (anaphylactic) reactions are required to bring a personal supply of epinephrine, preferably in a pre-loaded auto-injector, and know how to use it.

25. Is applicant allergic to or have a medically related intolerance to any food?  YES  NO

Describe: \_\_\_\_\_

26. Does the applicant have any dietary preferences? (e.g., vegetarian, vegan)  YES  NO  
(NOLS may not be able to accommodate all preferences)

Describe: \_\_\_\_\_

27. Has the applicant had any systemic allergic reactions to insects, bee/wasp stings, or medications resulting in hives, swelling of face/lips or difficulty breathing?  YES  NO

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

\_\_\_\_\_

28. Any other allergies?  YES  NO

Examiners Specific Comments: \_\_\_\_\_

\_\_\_\_\_

29. 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 supervision or assistance from NOLS staff.**

Medication	Dosage	Date Prescribed?	Prescribed by?	For What Conditions?
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If medications or health condition changes prior to course start, please inform NOLS.

## Cold, Heat, Altitude

30. History of frostbite or Raynaud's Syndrome?  YES  NO

31. History of acute mountain sickness, high altitude pulmonary/cerebral edema?  YES  NO

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

\_\_\_\_\_

32. History of heat stroke or other heat related illness?  YES  NO

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

\_\_\_\_\_

## Fitness

Please provide details concerning the student's exercise regime:

33. 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

34. Does this person smoke or use tobacco products?  YES  NO

Tobacco (or nicotine) is not allowed on NOLS courses or property. We recommend that the applicant quit now.

35. Is this person underweight? overweight? If so, how much? \_\_\_\_\_  YES  NO

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

## Physical Examination

A D.O., M.D., F.N.P., APRN or P.A. 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 travel information for specific details.

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
Blood Pressure      Pulse      Last Tetanus Inoculation      Height (inches)      Weight (lbs.)

General Appearance, Impressions and Comments:

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\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Examiner's Name      Phone

Street

\_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
City      State      Zip

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
M.D., D.O., F.N.P., APRN or P.A. Signature      Date:

**By my signature, I attest that the person named on page 1 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.**