

# H E A L T H F O R M

<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 <input type="checkbox"/> Female <input type="checkbox"/> Male	Age _____	NOLS Grad <input type="checkbox"/> Non Grad <input type="checkbox"/>

### NOLS Expedition Information for the Medical Professional

National Outdoor Leadership School courses 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.

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.

**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

**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  
(provide name/address)

If "yes" please specify the issue(s)

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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:

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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, angina, tachycardia, bradycardia, unexplained chest pain 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 does he/she have a history within the past 3 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? YES NO  
• 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? YES NO  
• 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 you: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 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 he/she had psychotherapy?  YES  NO

22. Is he/she currently in treatment or psychotherapy?  YES  NO

23. Reasons for treatment or therapy?

suicide

substance abuse/chemical dependency

eating disorder (anorexia/bulimia)

academic/career/family issues

ADD/ADHD

anxiety

depression

other \_\_\_\_\_

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

24. Name and telephone number of psychotherapist?

\_\_\_\_\_  
Name

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



**Allergies**

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

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

26. Does he/she have any dietary preferences? YES NO  
(NOLS may not be able to accommodate all preferences)

Describe \_\_\_\_\_

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

If appropriate please bring a personal supply of epinephrine, preferably in a pre-loaded autoinjector, and know how to use it.

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	Side Effects/Restrictions	Prescribed by?	For What Conditions?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**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 applicant quit now.

35. Is this person overweight? Underweight? 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              Weight

General Appearance, Impressions and Comments:

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

\_\_\_\_\_                                      \_\_\_\_\_              \_\_\_\_\_  
Street Address                                      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 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

