HEALTH FORM

____________________  ______  ______  ______
Student’s Name        Age        Course Code  Application ID#

INFORMATION FOR THE STUDENT AND/OR PARENT/GUARDIAN

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 this health form. A “Yes” answer does not automatically cancel your enrollment. It is your responsibility, in conjunction with your healthcare provider, to determine if the course is appropriate and that you can participate fully. If we have any questions on your capacity to complete the course, we will contact you to discuss it. However, failure to disclose a health condition that becomes relevant while on your course may result in dismissal from NOLS without a refund.

By my signature, I confirm that the information provided on this form will be an accurate and complete representation of my (or the minor student’s) health history. I also understand that NOLS’ admission of me (or the minor student) to the course is not intended as a representation that NOLS staff will be able to successfully manage a medical event or emergency related to a disclosed, or undisclosed, medical condition.

__________________________________________________________
Student Signature OR Parent/guardian signature if student is a minor.  ______/_____/_____
Month    Day            Year

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

INFORMATION FOR THE MEDICAL PROFESSIONAL

Remoteness: 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 on the NOLS website.

Living conditions: While participating on a NOLS expedition, students will sleep outdoors, set up their own tents and shelters and share these with one to four other people, cook their own meals and eat and in groups of two to four people. Weather conditions can be extreme, depending on the course type, and may change rapidly. Each student is expected to take care of themselves.

Physical demands: Students can expect to experience physically and emotionally demanding days. Backpacking courses require carrying a backpack that may weigh up to 60 pounds or more over rough and rugged mountainous terrain. Water-based courses may 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 dioxide or by boiling. Chlorine dioxide may not be 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 or using nicotine, using alcohol or, drugs, or treat behavioral or psychological conditions.

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

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 (we suggest two, having one as a backup). An aerochamber/spacer is also recommended.*

   What triggers an attack? Last episode? Ever been hospitalized for asthma? ________________________________________________________________________________

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/vertigo or fainting episodes?
   - YES
   - NO

9. Migraines? Medications, frequency, are they debilitating?
   - YES
   - NO

   *For questions 6-9, please describe frequency, date of last episode, and severity.*

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

10. Disorders of the urinary or reproductive tract?
    - YES
    - NO

______________________________________________________________________________

11. Is the applicant pregnant?
    - YES
    - NO
    - N/A

    *(Due to the risk of complications in a remote environment, NOLS does not allow students to attend who are pregnant)*
Cardiac History

12. Any history of cardiac illness or significant risk factors, such as known coronary artery disease, hypertension, diabetes mellitus, 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: ____________________________________________________________
___________________________________________________________________________________

Muscle/Skeletal Injuries/Fractures

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

13. Knee, hip, leg, 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 range of motion? Full Strength?

- YES
- NO

What is the most rigorous activity participated in since the injury/surgery? ______________________
___________________________________________________________________________________

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

14. 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 range of motion? Full Strength?

- YES
- NO

What is the most rigorous activity participated in since the injury/surgery?
___________________________________________________________________________________

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

15. 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)
___________________________________________________________________________________
Examiner’s specific comments: (include date of last occurrence and the effect of the problem on current activity level) _____________________________________________

Mental Health

Applicants with a history of a mental health condition within the past three years, which may have required psychotherapy, medication, 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 a therapeutic school and is not appropriate for applicants just leaving residential treatment facilities.

17. Has the applicant been diagnosed or treated for a mental health condition? □ YES □ NO
18. Is the applicant currently prescribed medication or engaged in psychotherapy for any of the conditions or symptoms noted below? □ YES □ NO
19. Please indicate any of the following conditions or symptoms that have been present.
   □ suicide (thoughts, ideation, attempt) □ ADHD □ autism spectrum disorder
   □ substance use disorder (drugs/alcohol) □ anxiety □ PTSD
   □ eating disorder (anorexia/bulimia) □ depression □ self-harm
   □ obsessive-compulsive disorder □ bipolar disorder
   □ academic/career/family issues □ other ____________________________

Please Provide Specific Details and dates of diagnoses and psychotherapy:
______________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

20. Does the applicant have any other physical, cognitive, or sensory condition that would require consideration? □ YES □ NO
If yes, please describe how the condition affects the applicant: _____________________________________________
___________________________________________________________________________
___________________________________________________________________________

21. Will this person take any prescription or non-prescription medications on the course? □ YES □ NO
Students who have been prescribed medications by their health care provider must understand the use of their medication and be able to take their medication as prescribed on their own without supervision or assistance from NOLS instructors.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Date First Prescribed</th>
<th>For What Condition?</th>
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If medications or health condition change prior to course start, please inform NOLS.
Allergies

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

22. Is applicant allergic to or have a medically related intolerance to any food? ☐ YES ☐ NO
Describe: _____________________________________________________________

23. Does the applicant have any dietary preferences? (e.g., vegetarian, vegan, gluten free) ☐ YES ☐ NO
NOLS may not be able to accommodate all preferences.
Describe: ________________________ ______________________________________

24. 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: ___________________________________________________________________________________

25. Any other allergies? ☐ YES ☐ NO
Examiners Specific Comments: ____________________________________________________________

Cold, Heat, Altitude, Ocean

26. History of frostbite or Raynaud’s Syndrome? ☐ YES ☐ NO

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

28. Do you have a history of seasickness? ☐ YES ☐ NO

29. History of heat stroke or other heat related illness? ☐ YES ☐ NO
When did the injury or illness occur?__________________________________________

30. Any other disease or surgery not already mentioned? ☐ YES ☐ NO
Examiner’s specific comments: ___________________________________________________________________________________

Fitness

31. 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

32. Does this person smoke, vape, or use tobacco products? ☐ YES ☐ NO
Tobacco or nicotine is not allowed on NOLS courses or property. The applicant should quit now.

33. Is this person underweight? overweight? If so, how much? ____________________ ☐ YES ☐ NO
34. Swimming ability (CHECK ONE): □ Non-swimmer □ Recreational □ Competitive

Physical Examination

The physical examination cannot be more than one year 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 (ft/inches)  Weight (lbs.)

General Appearance, Impressions and Comments:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

_____________________________  (______)________________________
Examiner’s Name  Phone

___________________________________  __________________________
Street  Street
___________________________________  __________________________
City  State  Zip

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 them.

___________________________________  __________ / __________ / ________
Signature  M.D., D.O., F.N.P., APRN or P.A.  Month  Day  Year: