High Adventure Activity Medical Form

This form is valid for 12 months.
This form should be kept at the Troop level.
Please attach to the AHG Health and Medical History Form.

Participant Name: _____ DOB: _____/_____/_____ Age: _____

Emergency Contact Name: _____ Phone #: _____

Health Examination: To be completed by a Licensed Health-Care Provider

The applicant will be participating in a strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge, or wilderness expedition (afoot or afloat) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue, and/or remote condition where readily available medical care cannot be assured.

Date of Exam: _____ Height _____ Weight _____ B.P _____/_____ Pulse _____	**Vision:** Normal _____ Glasses _____ Contacts _____	**Hearing:** Normal: _____ Abnormal: _____

Check box if normal; circle if abnormal and give details below:

☐ Growth, development	☐ Teeth, tonsils	☐ Genitourinary	☐ Skin, glands, hair
☐ Respiratory	☐ Skeletomuscular	☐ Head, neck, thyroid	
☐ Cardiovascular	☐ Neuropsychiatric	☐ Eyes, ears, nose	☐ Abdomen, hernia, rings
☐ Other (specify)			

Comments/Details: _____

_____

_____

_____

Dietary Restrictions

_____

Approved for participation in:

___ Hiking ___Water Activities ___ Competitive Sports ___ All activities

Specify exceptions:

_____

_____

Recommendations (explain any restrictions OR limitations)

_____

_____

_____

Is medication information on the Health and Medical History Form up to date and current? YES NO
If no, please provide updated information. Attach a separate sheet if needed.

_____

_____

Signature of Licensed Health Care Practitioner (AHG, Inc. allows **MD, DO, PA, CNP** to sign)

_____ Date _____

Address: _____ Phone: _____

City, State, Zip: _____

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