Medical Form

UNC Charlotte Discovery Program

Name_____Birth Date _____Social Security #_____.

Address_____Phone (___)_____

In Case of Emergency, Contact: _____
name and relationship

Emergency Contact Phone#: _____ Emergency Contact Phone #2:_____

ATTENTION MEDICAL PROFESSIONAL:
PLEASE READ THE FOLLOWING
Discovery Course Information

Discovery is a 19 day wilderness expedition. Expeditions operate in remote areas where evacuation to modern medical facilities can take hours or days.

Weather conditions can be extreme. Prolonged storms, high winds, intense sunlight, and sudden immersion in cold water is possible.

The applicant will be carrying a pack of 45-75 pounds on uneven terrain at elevations up to 7,000 feet locally or paddling heavily loaded canoes. While participating in a wilderness course, this student will sleep outdoors, experience long hard days, will prepare meals and set-up camp. The program may include rock climbing, a 14-mile run on rugged terrain, and an experience of fasting and solitude lasting up to 2 days. Each student is expected to take good care of his or her health.

Discovery is NOT a rehabilitation program. Discovery is NOT the place to quit smoking, drinking, or drugs.

Prior physical conditioning and an enthusiastic mental attitude are a necessity. Students find this program to be physically, mentally, and emotionally demanding.

In the interest of personal safety of both the applicant and other course members, please consider the above description carefully when completing the Medical 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 discuss it with you. The student is not accepted on the course until the Medical Form has been reviewed and approved by UNC Charlotte personnel.

(TURN FORM OVER TO COMPLETE EXAMINATION)
YOUR DETAILED COMMENTS WILL EXPEDITE OUR REVIEW OF THIS FORM!
Physician, F.N.P. or P.A.: Please circle **YES** or **NO** for each item. Each question must be answered.

GENERAL MEDICAL HISTORY

Does the applicant currently have or does he/she have a history of:

1.	Respiratory problems? Asthma?	1. YES NO
2.	Gastrointestinal disturbances?	2. YES NO
3.	Diabetes?	3. YES NO
4.	Hypertension?	4. YES NO
5.	Bleeding or blood disorders?	5. YES NO
6.	Hepatitis or other liver disease?	6. YES NO
7.	Neurological problems? Epilepsy?	7. YES NO
8.	Seizures?	8. YES NO
9.	Dizziness or fainting episodes?	9. YES NO
10.	Cardiac problems?	10. YES NO

Examiners specific comments:

_____.

_____.

_____.

CARDIAC SCREENING:

Applicants over 35 years of age with two or more of the following risk factors:

*obesity
*high blood pressure
*diabetes
*unexplained chest pain, shortness of breath or palpitations
*current or prior cardiovascular disease
*smoking more than one pack per day
*a family history of cardiac disease (heart attack at <55years)
*high blood cholesterol

and applicants over 50 years of age are required to have a stress ECG. We suggest, and may require, stress ECG for persons over 35 with a sedentary lifestyle. Please provide a written note from your Doctor as to the date of the ECG and its results.

11.	Treatment or medication for menstrual cramps?	11. YES NO
12.	Disorders of the urinary or reproductive tract?	12. YES NO
13.	Any other disease?_____	13. YES NO
14.	Does this person see a Medical or Physical specialist of any kind? If so, please give: Name and Address:_____ Name and Address:_____	14. YES NO
15.	Is she pregnant?	15. YES NO

Examiners specific comments:

_____.

_____.

_____.

(TURN FORM OVER TO COMPLETE EXAMINATION)

MUSCLE/SKELETAL INJURIES
Does the applicant currently have or does he/she have a history of:

16. Knee, hip or ankle injuries? 16. YES NO
17. Shoulder, arm or back injuries? 17. YES NO
18. Head injury? 18. YES NO
19. Any other joint problems? 19. YES NO

Examiners specific comments:
(Include date of last occurrence and the effect of the problem on current activity level)

_____.
_____.
_____.

PERSONAL HISTORY (COUNSELING/PSYCHIATRIC)

20. Has he/she had treatment or counseling with a mental health professional? 20. YES NO
21. Is he/she currently in treatment (including medication) or counseling? 21. YES NO
22. Name and address of therapist?_____
23. Hospitalization within the past year? 23. YES NO
24. Reasons for treatment or counseling?
    ____suicide gesture ____academic/career ____substance abuse/chemical dependency
    ____family issues ____eating disorder ____learning disability
    ____other

Examiners specific comments: (Please note <u>any</u> changes to medications within the last 30 days.)

_____.
_____.
_____.

ALLERGIES

25. Any allergies?_____ 25. YES NO
26. Is iodine contraindicated for this person? 26. YES NO
27. Is he/she allergic to any foods? Are there any dietary restrictions? Vegetarian? 27. YES NO
28. Allergic to insect bites or bee stings? 28. YES NO

Examiners specific comments:

_____.
_____.
_____.

MEDICATIONS – Please make a note if there has been any change in medications in the last 30 days

29. Is he/she allergic to any medications?_____ 29. YES NO
30. Is he/she currently taking any medications? Specify dose and reason for taking. 30. YES NO

Medication	Dosage (amt./freq.)	Side Effects/Restrictions
_____	_____	_____
_____	_____	_____
_____	_____	_____

Examiners specific comments:

_____.
_____.
_____.

(TURN FORM OVER TO COMPLETE EXAMINATION)

COLD, HEAT, ALTITUDE

31. History of Frostbite, Hypothermia or Raynaud's Syndrome? 31. YES NO
32. History of Acute Mountain Sickness or Cerebral Edema? 32. YES NO
33. History of heat stroke or other heat related illness? 33. YES NO

Examiners specific comments:

_____.
_____.
_____.

FITNESS

34. Does the applicant exercise regularly? 34. YES NO

			INTENSITY LEVEL:		
ACTIVITY	FREQUENCY	DURATION/DISTANCE	EASY	MODERATE	COMPETITIVE
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____
_____	_____	_____	____	_____	_____

35. Does this person smoke? If so, how much?_____ 35. YES NO
    There is no smoking on Discovery courses. We recommend that you quit now.
36. Is this person overweight? Underweight? If so, how much?_____ 36. YES NO
37. Swimming ability (check one):____Non-Swimmer____Recreational____Competitive

PHYSICAL EXAMINATION

Physical examination data cannot be more than a year old from the starting date of the Discovery course – May 10, 2020. (Please type or print legibly) Tetanus shot must be current. UNC Charlotte/Discovery requires a tetanus immunization within 10 years of the start date of the course.

1. Blood Pressure:_____Pulse_____ Last Tetanus Inoculation?_____
   Blood Type_____ Height:_____Weight:_____

2. General Appearance:

3. On the basis of the background information at the beginning of this form and your examination, do you feel that this individual can participate in this Discovery course?

   The medical examiner must check:
   _____***YES, I think this person can participate.***
   _____***NO, this person should not participate at this time for the reasons explained.***

4. General impressions or comments and any additional Information that we should be aware of:

Examiners name:_____ Phone: (____)_____

Address:_____

PHYSICIAN, F.N.P. OR P.A. SIGNATURE:_____Date:_____

PLEASE RETURN COMPLETED MEDICAL FORM TO:
Brian Holcomb, UNC Charlotte Venture Program, 9201 University City Blvd, Charlotte NC, 28223