ATTENTION MEDICAL PROFESSIONAL:

PLEASE READ THE FOLLOWING

SOAR Outdoor Orientation Program

SOAR Outdoor is a five-day, four-night, backpacking program in the Western North Carolina mountains. The program includes extended periods where the group will operate in remote areas where evacuation to comprehensive medical care can take hours.

Weather conditions can be extreme. Prolonged storms, high winds, intense sunlight, hot and cold temperatures are possible, as well as sudden immersion in cold water.

The applicant will be carrying a pack of 25-40 pounds on uneven terrain. While participating in this course, this student will sleep outdoors, experience long hard days, prepare meals, and set-up camp. The group will live in close community during this program with little opportunity for self-directed scheduling.

Each student is expected to take good care of his or her health. The ability of the student to persevere in challenging circumstances (such as cold weather, long days, sore muscles, etc.), be of sound mind to make good decisions, and be of average-above average physical ability will play a significant part in the safety of the individual and the group. Prior physical conditioning and an enthusiastic mental attitude are a necessity. Students find wilderness experiences 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

Examiner's 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 <55 years)
* high blood cholesterol

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 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: ___________________________________________________________

15. Is she pregnant? 15. YES NO

Examiner’s specific comments:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
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

Examiner’s 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?
   ___ suicidal gesture  ___ academic/career  ___ substance abuse/chemical dependency
   ___ family issues  ___ eating disorder  ___ learning disability
   ___ depression  ___ other
Examiner’s specific comments: (Please note any 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
Examiner’s 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

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<th>Medication</th>
<th>Dosage (amt./freq.)</th>
<th>Side Effects/Restrictions</th>
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Examiner’s specific comments:
________________________________________________________________________
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(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:

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<tr>
<th>ACTIVITY</th>
<th>FREQUENCY</th>
<th>DURATION/DISTANCE</th>
<th>EASY</th>
<th>MODERATE</th>
<th>COMPETITIVE</th>
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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 SOAR Outdoor Program, _________. (Please type or print legibly) Tetanus shot must be current. UNC Charlotte Venture Program requires a tetanus immunization within 10 years of the start date of the program.

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 the SOAR Outdoor Program?
   The medical examiner must check:
   _____ YES, I think this person is able to participate.
   _____ NO, this person should not participate at this time for the reasons explained below.
   __________________________________________________________.
   __________________________________________________________.

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

Examiner’s 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 Boulevard, Charlotte, NC 28223