2022 MEDICAL EVALUATION FORM

To be completed by a Licensed Healthcare Practitioner | Required for any participant diagnosed with cancer

NOTE TO LICENSED HEALTH CARE PRACTITIONERS: Your patient will be attending a whitewater adventure program for a week in a remote wilderness area that includes some hiking, rafting, camping and group activities down the Main Salmon River from Salmon, ID to Riggins, ID. Each day meets the ACS guidelines for physical activity of 150 minutes of moderate intensity activity throughout the week. We will be camping in tents and sleeping on camping mattresses on the sand. Patient must also be able to get up and down from a laying position with minimal assistance and be able to rotate body from a front float to a back float if in the water.

If the participant has had a medical evaluation within the prior 3 months by a licensed health care practitioner, you may attach a copy in lieu of this medical evaluation, but you must still have a practitioner's signature and date on this application. The evaluation must include the practitioner's signature and date. A recent examination within the past 3 months is required of any participant who is currently under medical care, requires a medically prescribed diet, has had an injury or illness during the past 3 months that limited activity for a week or more, has ever lost consciousness during physical activity, or has suffered a concussion from head injury.

Patient Name _____ DOB _____/_____/_____ Age_____

Review the health history with the participant for any interim changes. Explain any "abnormal" evaluations - attach additional sheets as needed.

PHYSICAL EXAMINATION: *(to be completed by a licensed health-care practitioner)*

Height _____ Weight _____ BP _____/_____ Pulse _____

Oncology Diagnosis: _____ Diagnosis date: _____

Other Medical Conditions/Diagnosis: _____

_____

Medication *(Please list or attach a list of current meds including dose, route, frequency)*: _____

_____

Please be advised: no electricity is available for the week your patient is attending the program.

Does this patient use medical equipment daily that requires electricity? _____

Does this patient have any open wounds or stitches?_

VISION: Normal _____ Glasses _____ Contacts _____

HEARING: Normal _____ Abnormal _____ Explain _____

URINALYSIS: *(when indicated)* Albumin_____ Sugar _____

NEUROPATHY: please explain any challenges or limitations: _____

_____

Check Box:	**Norm**	**Abn**		**Norm**	**Abn**		**Norm**	**Abn**
Growth development	☐	☐	Teeth	☐	☐	Genitalia	☐	☐
Skin	☐	☐	Cardiopulmonary	☐	☐	Musculoskeletal	☐	☐
HEENT	☐	☐	Hernia	☐	☐	Neurobehavioral	☐	☐
Respiratory	☐	☐	Gastrointestinal	☐	☐	Integument	☐	☐

Explain any abnormal findings: _____

_____

Circle any of the following that apply. Use of: Brace Splint Prosthetic Cane Crutch

Additional information or concerns: _____

_____

Loss of Balance/Coordination _____ Details _____

Previous injury or ailment that may give you trouble occasionally: _____

Circle all the following physical symptoms from cancer patient may be currently experiencing:

Fatigue Nausea Pain Diarrhea Other _____

Approved for all activities? *(Hiking, Camping, Whitewater rafting, and Vigorous sports)* **Yes** **No**

Activity Restrictions (if any):_____

Diet restrictions _____

Other Issues/Information _____

COVID-19 (Coronavirus Status) _____

Vaccine Completed (date):_____

If you recommend participant NOT receive the COVID vaccine, please state the medical reason(s):_____

_____

Healthcare Professional Name *(print)* _____ **Phone** _____

Healthcare Business Name:_____

Signature_____M.D./D.O./N.P/PA-C **Date** _____

Address _____

City, State, Zip _____

If utilizing a stamp please stamp here: