



MONTANA WILDERNESS SCHOOL
YOUTH MEDICAL & EMERGENCY INFORMATION
AND CONSENT FOR MEDICAL/SURGICAL/EMERGENCY TREATMENT AND TRANSPORT

The Montana Wilderness School highly recommends that every student schedule a pre-expedition physical exam with a medical doctor to insure they are physically capable of participating on the expedition. Please provide complete answers to all questions

GENERAL INFORMATION:

Name: Male Female

Phone # (home) (work) (mobile)

Address:

Parent/Guardian Name:

Phone # (home) (work) (mobile)

Address:

PRIMARY EMERGENCY CONTACT:

Name: Relationship:

Phone # (home) (work) (mobile)

Address:

ALTERNATIVE EMERGENCY CONTACT:

Name: Relationship:

Phone # (home) (work) (mobile)

Address:

INSURANCE COVERAGE: Each participant is responsible for her/his own medical expenses, including the cost of medical evacuation. Each participant is required to have her/his own medical insurance through an annual policy or a travel medical policy during the expedition. Medical evacuation is expensive and may not be covered under a medical insurance policy. It is strongly recommended that medical evacuation coverage be verified under an existing policy or purchased separately for the expedition. It is advisable to consider trip cancellation insurance.

Medical Insurance company: Policy number:

Medical Insurance company phone #:

Does insurance company require pre-authorization? Yes No If Yes, Phone #:

Physician/Health Care Provider's Name: Phone #:

Evacuation Insurance company: Policy number:

Evacuation Insurance company phone #: Check if no insurance

Does insurance company require pre-authorization? Yes No If Yes, Phone #:

**MEDICAL AND PHYSICAL INFORMATION:**

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Current tetanus vaccination?  Yes  No

**Exercise routine:** Detail your current activity below -or-  None

<i>Activity Level</i>	<i>Frequency Per Week</i>	<i>Approximate Time / Distance</i>	<i>Intensity</i>

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**SWIMMING ABILITY:**  Cannot Swim  Can Swim 100 feet  Can Swim 500 feet  Strong Swimmer

**ALLERGIES:** Please list all allergies including medicines, food, bites, stings, plants, and animals:

No allergies

<i>Allergy</i>	<i>Reaction</i>	<i>Medication required</i>
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**MEDICATIONS:** Please list all prescription and non-prescription medications you take and/or carry with you:

No medications

<i>Medication</i>	<i>Condition</i>	<i>Dosage (amount/frequency)</i>	<i>Medication Initiated (month/year)</i>	<i>Side Effects</i>
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**HEALTH HISTORY:** Please check the appropriate box, and respond to all questions below:

Yes No

1. Diabetes: If yes, is participant insulin-dependent? Yes  No
2. Asthma or other respiratory problems?
3. Does participant smoke?
4. Any cardiac conditions, including high/low blood pressure, heart murmur, or irregular heartbeat?
5. Epilepsy or a seizure disorder: If yes, date of last seizure: \_\_\_\_\_
6. Bleeding disorders, anemia?
7. Neck/Back/Knee/Shoulder/Ankle problems?
8. Pregnant: If yes, what trimester? \_\_\_\_\_
9. Hospitalization/Emergency Room visit in the past year?
10. Operations/ Serious Injuries in the past five years?
11. Diagnosed eating disorder of any kind such as anorexia or bulimia
12. Anxiety

13. Other past or current medical issues/illness/requirements?  
  14. Counseling with a psychiatrist/psychologist/counselor within the past two years? Currently ongoing?  
Yes  No

If any of the boxes above were checked yes, please provide a description including history, symptoms, hospitalizations, and any restrictions. Please refer to the number listed by the issue above, and attach additional pages as necessary. Be sure to detail any medications on page two.

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Are there any physical or medical conditions not listed above which may affect or limit participation?

Yes  No  If Yes, please explain (attach additional sheets as necessary):

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Dietary Restrictions: Are there any special dietary requirements? (vegetarian, lactose intolerant, food allergies, gluten free, etc.)

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Please list any other information such as a recent traumatic event that may be helpful for us to know about to help ensure the student's physical or mental health on his/her expedition. (Attach additional pages as necessary)

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**PLEASE READ CAREFULLY:**

- **Please review the medical section of the form to be certain you have answered every question. A complete Medical and Emergency Information Form is required for participation in this program.**
- **All information on this form is confidential. It is possible to participate in our programs while having some medical/psychological difficulties, but the Montana Wilderness School must be aware of these conditions. Failure to disclose medical and health history information as requested could result in serious harm to the student and other participants in the program.**
- **The status of the student's participation will be determined after review of this form. In some cases further evaluation, possibly including consultation with your health care provider, may be necessary.**

- **Please review the Montana Wilderness School Acknowledgement and Assumption of Risks & Release and Indemnity Agreement. Pursuant to it, you are required to defend and reimburse Montana Wilderness School (including, but not limited to, its employees) if a hospital, medical, or evacuation provider attempts to collect payment from it for any services.**

**CONSENT FOR MEDICAL/SURGICAL/EMERGENCY TREATMENT AND TRANSPORT**

**SIGNATURES REQUIRED**

Consent is hereby voluntarily given for the applicant to attend a Montana Wilderness School program, and **for the Montana Wilderness School field staff to administer first aid to the participant in the back-country.**

**Some medical conditions in the field will result in an evacuation and consent is hereby voluntarily given for field evacuation of the participant.**

**Consent is hereby voluntarily given to the rendering of such care, including diagnostic procedures, surgical and medical treatment and blood transfusions, by authorized members of health care providers or their designees, as may be necessary in their professional judgment.**

I hereby acknowledge that no guarantees have been made as to the effect of such examinations or treatment on participant's condition.

I acknowledge that I am responsible for any and all charges in connection with the care, treatment, and transport of the participant.

I have read and understand this information and consent form. The information I provided is, to the best of my knowledge, correct and complete.

\_\_\_\_\_  
Applicant's signature Date \_\_\_\_\_

\_\_\_\_\_  
Signature of parent/guardian Date \_\_\_\_\_