HEALTH FORM

NOLS

For NOLS Office Use Only	❑ Initial Review OK	❑ Detailed Review OK
❑ Check Further	Date ___/___/___	AO Initials _________

_______________________ Student's Name

_______________________ Course Code

_______________________ Application ID#

(_______)_______________________ Daytime or Temporary Phone (circle one)

(_______)_______________________ Permanent Phone

Sex __________ Age __________ NOLS Grad ❑ Non-Grad ❑

Information for the Medical Professional

Field courses offered by the National Outdoor Leadership School (NOLS), are wilderness expeditions operating in remote areas of the world where evacuation to modern medical facilities may take days. There is a detailed course description for every course found here: http://www.nols.edu/courses/

Living conditions While participating on a NOLS expedition, students will sleep outdoors, experience long and physically demanding days, set up their own camp and prepare their own meals. Weather conditions can be extreme depending on the course type. Each student is expected to take good care of themselves. On some courses, students may have the option to fast.

Physical demands on the applicant are considerable. Backpacking courses require carrying a backpack that may weigh up to 60 pounds or more over rough and rugged mountainous terrain. Water-based courses may require sitting and paddling continuously for long periods of time and walking on rugged shorelines while carrying heavy items.

Water disinfection. NOLS disinfects all wilderness water with chlorine, chlorine dioxide, or by boiling. Not all of these methods are effective against cryptosporidium. Immunocompromised people may wish to obtain an appropriate water filter for their course.

NOLS is not a rehabilitation program. NOLS is not the place to quit smoking, drinking, or drugs or to work through behavioral or psychological problems.

Prior physical conditioning and a positive attitude are a necessity. Students find a NOLS course to be an extremely demanding experience both physically and emotionally.

Full Disclosure: In the interest of the health and well-being of both the applicant and the other expedition members, please answer the questions honestly and completely when completing the health 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 call the student to discuss it. However, failure to disclose a health condition that becomes relevant while on your course may result in dismissal from NOLS.

NOLS HEADQUARTERS | 284 LINCOLN ST. LANDER, WY 82520, USA | 1.800.710.6657 | NOLS.EDU

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The applicant is not accepted on the course until the health form has been reviewed and approved by NOLS personnel.

Your detailed comments will expedite our review of this form.

M.D., D.O., F.N.P., APRN or P.A.:
Please check YES or NO for each item. Each question must be answered and please **provide date and details for all "yes" answers.**

General Medical History

Does the applicant currently have or have a history of:

1. Respiratory problems? Asthma? ❑YES ❑NO

Is the asthma well controlled with an inhaler? ❑YES ❑NO ❑N/A

If so, please have the student bring one or more metered dose inhalers (MDI) with them for their course and an aerochamber/spacer is recommended.

What triggers an attack? Last episode? Ever Hospitalized?

____

____

____

2. Gastrointestinal disturbances? ❑YES ❑NO

3. Diabetes? ❑YES ❑NO

Examiner's specific comments: ____

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4. Bleeding, DVT (deep vein thrombosis) or blood disorders? ❑YES ❑NO

5. Hepatitis or other liver disease? ❑YES ❑NO

Examiner's specific comments: ____

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6. Neurological problems? Epilepsy? ❑YES ❑NO

7. Seizures? ❑YES ❑NO

8. Dizziness/vertigo or fainting episodes? ❑YES ❑NO

9. Migraines? Medications, frequency, are they debilitating? ❑YES ❑NO

6-9. Describe frequency, date of last episode, and severity.

____

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10. Disorders of the urinary or reproductive tract? ❑YES ❑NO

11. Any disease? ❑YES ❑NO

12. Does this person see a medical or physical specialist of any kind? ❑YES ❑NO

If "yes" please provide name/address and specify the issue(s):

____

____

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13. Treatment or medication for menstrual cramps? ❏YES ❏NO ❏N/A

14. Is the applicant pregnant? ❏YES ❏NO ❏N/A

Examiner's specific comments: ______________________________

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Cardiac History

15. Any history of cardiac illness or significant risk factors, such as known coronary artery disease, hypertension, diabetes, hyperlipidemia, tachyarrhythmia, symptomatic bradycardia (syncope, dizziness), unexplained chest pain (especially with exercise) or immediate family history of early cardiac death (<50 years old)? ❏YES ❏NO

Depending on the applicant's history, risk factors and age, a stress ECG or waiver from their cardiologist may be required.

Examiner's specific comments: ______________________________

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Muscle/Skeletal Injuries/Fractures

Does the applicant currently have or have a history within the past three years of:

16. Knee, hip, leg, or ankle injuries (including sprains) and/or surgery? ❏YES ❏NO

- Type of injury or surgery? When did the injury or surgery occur? ______________________________

____

____

- Is there full ROM? Full Strength? ❏NO ❏YES
- What is the most rigorous activity participated in since the injury/surgery. Results? ______________

____

____

Examiner's specific comments: (include date of last occurrence and the effect of the problem on current activity level)

____

____

17. Shoulder, arm or back injuries (including sprains) and/or surgery? ❏YES ❏NO

- Type of injury or surgery? When did the injury or surgery occur? ______________________________

____

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- Is there full ROM? Full Strength? ❏NO ❏YES
- What is the most rigorous activity participated in since the injury/surgery. Results?

____

Examiner's specific comments: (include date of last occurrence and the effect of the problem on current activity level) ______________________________

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18. Any other joint problems? ❑ YES ❑NO

Examiner's specific comments: (include date of last occurrence and the effect of the problem on current activity level) ____________________

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19. Head Injury? Loss of consciousness? For how long? ❑YES ❑NO

Examiner's specific comments: (include date of last occurrence and the effect of the problem on current activity level) ____________________

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20. Does the applicant have any physical, cognitive, sensory, or emotional condition that would require consideration? ❑YES ❑NO

If yes, please describe how the condition affects the applicant: ____________________

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Mental Health

Students with a history of psychotherapy that required medication or has included hospitalization or residential treatment, need to be in a period of stability ranging from six months to two years, depending on the condition, before they will be accepted for a course. Applicants need to be gainfully occupied such as attending school or employed. NOLS is not appropriate for applicants just leaving residential treatment facilities.

21. Has the applicant had psychotherapy? ❑YES ❑NO

22. Is the applicant currently in treatment or psychotherapy? ❑YES ❑NO

23. Reason(s) for treatment or therapy?

- ❑ suicide (thoughts, ideation, attempt)
- ❑ substance use disorder (drugs/alcohol)
- ❑ eating disorder (anorexia/bulimia)
- ❑ obsessive-compulsive disorder
- ❑ academic/career/family issues
- ❑ ADHD
- ❑ anxiety
- ❑ depression
- ❑ bipolar disorder
- ❑ other ____________________
- ❑ autism spectrum disorder
- ❑ PTSD

Please Provide **Specific** Details of psychotherapy and dates medications were prescribed:

____

____

____

____

24. Name and telephone number of psychotherapist?

____________________ (____)____________________

Name Phone

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Allergies

Regardless of the allergen, individuals with a history of severe allergic (anaphylactic) reactions are required to bring a personal supply of epinephrine, preferably in a pre-loaded auto-injector, and know how to use it.

25. Is applicant allergic to or have a medically related intolerance to any food? ❑YES ❑NO

Describe: ____

26. Does the applicant have any dietary preferences? (e.g., vegetarian, vegan, gluten free) ❑YES ❑NO
(NOLS may not be able to accommodate all preferences)

Describe: ____

27. Has the applicant had any systemic allergic reactions to insects, bee/wasp stings, or medications resulting in hives, swelling of face/lips or difficulty breathing? ❑YES ❑NO

Examiner's specific comments: ____

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____

28. Any other allergies? ❑YES ❑NO

Examiners Specific Comments: ____

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29. Does this person plan to take any prescription or non-prescription medications on the course?
❑YES ❑NO

> **NOLS courses travel in remote areas where access to medical care may be one or more days away. The student must understand the use of any prescription medications they may be taking. All students who are required by their personal physician, psychiatrist or health care provider to take prescription medications on a regular basis must be able to do so on their own and without supervision or assistance from NOLS staff.**

Medication Dosage Date Prescribed? Prescribed by? For What Conditions?

____

____

____

If medications or health condition changes prior to course start, please inform NOLS.

Cold, Heat, Altitude

30. History of frostbite or Raynaud's Syndrome? ❑YES ❑NO

31. History of acute mountain sickness, high altitude pulmonary/cerebral edema? ❑YES ❑NO

When did the illness occur?____

____

32. History of heat stroke or other heat related illness? ❑YES ❑NO

Examiner's specific comments: ____

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Fitness

Please provide details concerning the student's exercise regimen:

33. Does the applicant exercise regularly? ❑YES ❑NO

Activity ______________________ Frequency ______________________

Duration/Distance ______________ Intensity Level ❑Easy ❑Moderate ❑Competitive

Activity ______________________ Frequency ______________________

Duration/Distance ______________ Intensity Level ❑Easy ❑Moderate ❑Competitive

34. Does this person smoke or use tobacco products? ❑YES ❑NO

Tobacco (or nicotine) is not allowed on NOLS courses or property. We recommend that the applicant quit now.

35. Is this person underweight? overweight? If so, how much? ______________ ❑YES ❑NO

36. Swimming ability (CHECK ONE): ❑Non-swimmer ❑Recreational ❑Competitive

Physical Examination

A D.O., M.D., F.N.P., APRN or P.A. must read and fill out pages 1-6. **Physical examination data cannot be more than a year old from the starting date of the NOLS course.** (Please type or print legibly.)

NOLS requires a tetanus immunization within 10 years of the start date of the course. Expeditions outside the U.S. may require additional immunizations. Please refer to your course travel information for specific details.

____________	________	_____/_____/_____	________	________
Blood Pressure	Pulse	Last Tetanus Inoculation	Height (inches)	Weight (lbs.)

General Appearance, Impressions and Comments:

____

____

____

______________________________________ (_____)______________________

Examiner's Name Phone

____

Street

______________________________________ __________ ______________

City State Zip

______________________________________ _____/_____/_____

Signature M.D., D.O., F.N.P., APRN or P.A. Date:

By my signature, I attest that the person named on page 1 of this form is medically cleared to participate on a NOLS course based on the expedition information provided on page 1 of this form along with the background information provided by the applicant and my physical examination of them.

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