AMERICAN HERITAGE GIRLS™
FAITH | SERVICE | FUN

High Adventure Activity Medical Form

Attach to Participant's Health and Medical Form

(Valid for 12 months from the date signed by the medical professional)

Participant Name _____ DOB: _____/_____/_____ Age _____
Emergency Contact
Name _____ Phone # _____

Health Examination

To be completed by a Licensed Health-Care Provider

The applicant will be participating in a strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge, or wilderness expedition (afoot or afloat) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue, and/or remote condition where readily available medical care cannot be assured.

Date of Exam _____
Height _____ Weight _____
B.P _____/_____ Pulse _____

Vision
Normal _____
Glasses _____
Contacts _____

Hearing
Normal _____
Abnormal _____

Check box, if normal; circle if abnormal and give details below:

☐Growth, development	☐Teeth, tonsils	☐Genitourinary
☐Skin, glands, hair	☐Respiratory	☐Skeletomuscular
☐Head, neck, thyroid	☐Cardiovascular	☐Neuropsychiatric
☐Eyes, ears, nose	☐Abdomen, hemia, rings	☐Other (specify)

COMMENTS _____

_____

_____

_____

Dietary Restrictions _____

Approved for participation in:

☐ Hiking	☐ Water Activities
☐ Competitive Sports	☐ All activities

Specify exceptions _____
_____

Recommendations (explain any restrictions OR limitations) _____
_____
_____

Is medication information on Health Form up to date and current? YES NO
If no, please provide updated information. Attach a separate sheet if needed. _____
_____
_____
_____

Signature _____ Date _____
Licensed Health-Care Practitioner

Address _____ Phone _____

City, State, Zip _____