To: Physician of Choice
From: New Vision Wilderness, LLC
Re: New Participants Physical Examination

Participant: _____ Exam Date: _____

Every employee of New Vision Wilderness must have a completed physical examination from an authorized physician.

Dear Doctor,

The above stated individual is going to participate in an outdoor adventure program. He/she may, on occasion, hike up to 10 miles a day in sometimes very hot/cold weather in wild and variable terrain. The participant will be carrying all of his/her equipment in a backpack and will be camping outdoors throughout the program.

We would appreciate your candid appraisal of the students' current health status. If you find the participant is 'fit' for this type of experience, please sign the physical form. If you find this participant 'un-fit' to manage such an experience, please be honest and open with the participant, the parents and New Vision Wilderness at this time.

Thank you,
Heidi Strand
Executive Director, New Vision Wilderness, LLC

PHYSICAL EXAM FORM
(to be completed by physician)

Physician Name _____ Phone # _____

Patient's name _____

Date of Birth: _____ Age: _____ Sex: _____

Height: _____ Ft. _____inches Weight: _____lbs

Blood Pressure: _____ / _____ Pulse Rate: _____ Pulse Irregularities: Yes No

(over)

Check (√) if normal, describe ONLY if abnormal.

Eyes _____
Ears _____
Nose _____
Throat & Mouth _____
Neck _____
Thyroid _____
Thorax & Lungs _____
Heart _____
Heart Murmer (if present) _____
Functional _____
Peripheral Vessels _____
Abdomen _____
Hernia _____
Genitals _____
Back _____
CNS _____
Lymph Nodes _____
Skin _____
Scars _____
Extremities _____
Shoulders _____
Knees _____
Ankles _____
Feet _____
Other _____

IMMUNIZATIONS: (list all dates) :

D.P.T. (series of 3)_____ / _____ / _____

Polio (series of 3)_____ / _____ / _____

MMR(series of 3)_____ / _____ / _____

HIB (18 mo.-5 yrs.)_____

Boosters _____

Boosters _____

Hepatitis B (series of 3)_____ / _____ / _____

Varicella (Chicken Pox) (after Jan. 1, 1998)_____

Please list any medical condition/medications NVW Staff should know about:

_____

_____

Please list any allergies (medications, food, plants etc.):

_____

_____

Expected reaction/treatment: _____

_____

TO BE COMPLETED BY DOCTOR:

_____ was examined on _____ and found to be in satisfactory health and free from communicable disease. There is no reason that this child should not participate in activities at New Vision Wilderness.

_____

Doctor Signature