



ENROLLMENT APPLICATION

**When complete, please return to:
Brandi Elliott, Admissions Director
Direct: 208-597-4445
Fax: 208-267-3232 or
Email: brandi.elliott@uhsinc.com**

Legal Guardian(s) or Person placing student in care if other than parent (if applicable)

Full Name _____ Relationship _____ Custody: Yes ___ Joint ___ No ___
 First Middle Last

Marital Status: Married ___ Single ___ Separated ___ Divorced ___

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Fax _____ E-mail _____

Social Security # _____ Religious Preference _____

Employer _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____

Business Phone _____ Business Cell Phone _____

Business Fax _____ Business E-mail _____

If any parent, stepparent, or adoptive parent of the student is deceased, please list name, date of death and age at death _____

Financial Sponsor (if applicable)

Is there a financial sponsor other than the parents? Yes ___ No ___

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Fax _____ E-mail _____

Business Phone _____ Business Cell Phone _____

Business Fax _____ Business E-mail _____

Sibling Information

Names and ages of sibling(s) (identify half, step, or adopted siblings) _____

If any of the siblings are not living at home, please provide the following information:

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Fax _____ E-mail _____

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Fax _____ E-mail _____

Emergency Contact Information

In case of emergency and parents cannot be reached, please notify:

Name #1 _____ Relationship _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____

Name #2 _____ Relationship _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____

I/We hereby authorize IES to contact the above emergency contacts if necessary and to disclose any information regarding the above named student to such emergency contacts that would have been released to me as a parent.

Parent/Guardian Name _____ Signature _____ Date _____

Parent/Guardian Name _____ Signature _____ Date _____

Out-of-Home Placement (if applicable)

Please list placements outside of the home: boarding schools, foster homes, psychiatric hospitalizations, etc.

Name and Location _____
Consulting Professional _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____ E-mail _____
Dates of Placement: From _____ To _____
Reason for Placement and Subsequent Departure _____

Name and Location _____
Consulting Professional _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____ E-mail _____
Dates of Placement: From _____ To _____
Reason for Placement and Subsequent Departure _____

I/We hereby authorize the above consulting professional(s) to release information regarding the above named student to IES.

Parent/Guardian Name _____ Signature _____ Date _____
Parent/Guardian Name _____ Signature _____ Date _____

Professionals Who Are Assisting the Student

Please list all educational consultants, psychiatrists, psychologists, and counselors/therapists who are currently working with the student.

If available, please attach to this application any psychological or psychiatric testing done on the student.

Name _____
Dates of Service: From _____ To _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____ E-mail _____
Nature of Service _____

Name _____
Dates of Service: From _____ To _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____ E-mail _____
Nature of Service _____

Name _____
Dates of Service: From _____ To _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____ E-mail _____
Nature of Service _____

I/We hereby authorize the above professional(s) to release information regarding the above named student to IES and authorize IES to release information regarding the student to the professionals indicated above.

Parent/Guardian Name _____ Signature _____ Date _____

Parent/Guardian Name _____ Signature _____ Date _____

Referral Information

How did you first hear about us? _____

If you were referred by a specific person, please provide the name of the person who referred you and their relationship to you or your child, e.g. educational consultant, therapist, school counselor, friend of family, IES parent, etc.

Name of Referral Source _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____ E-mail _____

If you want this person to receive updates on the student, please sign below.

Parent/Guardian Name _____ Signature _____ Date _____
Parent/Guardian Name _____ Signature _____ Date _____

Parental Assessment of the Student

1. Describe the student’s current behavior at home, your explanation for this behavior (your opinion), and how long this behavior has persisted. _____

2. Please provide any information about your family that would be helpful in assessing the student’s needs, including family history and relationships. _____

3. If student is not living with the biological parents, please explain why and describe the student’s relationship and communication with the biological parents. _____

4. Describe any traumatic events or major changes in the student’s life. _____

5. Describe the student's relationships with peers. _____

6. Describe the student's willingness to accept responsibility. _____

7. Describe the student's methods for expressing anger and disappointment. _____

8. Describe your goals for the student. _____

9. List the student's positive qualities, interests, and accomplishments. _____

10. Has the student ever experienced or exhibited any of the following? (If yes, please provide specific details.)

Arson or fire setting? Yes ___ No ___ Date _____ Police Intervention? Yes ___ No ___

Explain _____

Cruelty to animals? Yes ___ No ___ Date _____

Explain _____

Drug and/or alcohol use? Yes ___ No ___ (If yes, please describe type, if known, and frequency:
experimental, moderate, or heavy)

Explain _____

Self-abusive behavior? Yes ___ No ___ Date _____ Medical intervention required? Yes ___ No ___

Explain _____

Suicide discussion, threat or attempt? Yes ___ No ___ Date _____ Medical intervention required?
Yes ___ No ___

Explain _____

Assaultive/aggressive behavior? Yes ___ No ___ Date _____ (If yes, please describe toward whom: parents, other adults, siblings, peers)

Explain _____

Police intervention? Yes ___ No ___ Date _____
Explain _____

Running away? Yes ___ No ___ Date _____ (How many times and for how long?)
Explain _____

Did the student contact you while away? Yes ___ No ___
Explain _____

Eating disorder? Yes ___ No ___ Date _____ (If yes, please explain and list any medical intervention)
Explain _____

Sexual activity? Yes ___ No ___ Date _____
Explain _____

Physical/sexual abuse? Yes ___ No ___ Date _____ If yes, was there a witness to the abuse?
Yes ___ No ___
Explain _____

11. Describe the student's attitude toward and performance in school, including current and prior schools. _____

How long has this behavior persisted? _____

Held back a grade, expelled or withdrawn from school? Yes ___ No ___ Date _____
Explain _____

12. Has the student been diagnosed with learning difficulties? Yes ___ No ___
Explain _____

13. Have any academic/creative/intellectual strengths been identified? Yes ___ No ___
Explain _____

Please include with this application a transcript and any recent academic test results on the student.

14. Has the student ever taken any special education classes? Yes ___ No ___ Date _____

Explain _____

15. Does the student have an individualized education plan (IEP)? Yes ___ No ___ **(If yes, please include the most recent IEP with this application.)**

16. Describe any sudden shifts in academic performance. When did these occur? Are you aware of any precipitating factors? _____

17. Please list any additional comments regarding the student's behavior. _____

Probation Information (if applicable)

Is the student currently on probation? Yes ___ No ___ Date probation started and ends _____

Please attach a copy of probation order.

Probation officer's name _____ Progress updates required? Yes ___ No ___

Address _____ City _____ State _____ Zip _____

Telephone _____ Fax _____ E-mail _____

Reason for probation _____

Special conditions of probation _____

I/We hereby authorize the above probation officer to release information regarding the above named student to IES and authorize IES to release information regarding the student to the probation officer indicated above.

Parent/Guardian Name _____ Signature _____ Date _____

Parent/Guardian Name _____ Signature _____ Date _____

Consents and Releases

For purposes of these consents and releases, the term “IES” shall include ASCENT, Boulder Creek Academy, and Northwest Academy.

The term “Student” shall mean _____ .
(Print Student’s Name)

Academic Records Release

Please list all middle, junior and senior high schools the Student attended (most recent first) with complete addresses and phone numbers. (If additional space is needed, please use additional sheets.)

Currently or last enrolled at:

Name of School _____ Dates attended _____ Highest grade completed ____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____

If not currently enrolled, last date attended _____ Current grade ____

Name of School _____ Dates attended _____ Highest grade completed ____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____

Name of School _____ Dates attended _____ Highest grade completed ____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____

Name of School _____ Dates attended _____ Highest grade completed ____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____

Name of School _____ Dates attended _____ Highest grade completed ____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____

I/We hereby grant permission to release school transcripts to IES for the Student. Permission is granted to release the following records: official transcript of credit, withdrawal grades including incomplete classes, special education records, IEPs, test data, health records, disciplinary records, counseling information and records pertaining to psychiatric or psychological evaluations.

Parent/Guardian Name _____ Signature _____ Date _____

Parent/Guardian Name _____ Signature _____ Date _____

Release of Medical Information

Initials _____

I/We hereby authorize the release of any medical information regarding the Student to IES and authorize IES to release information regarding his/her prior medical history to medical providers as deemed necessary to facilitate the Student's medical care.

Release of Medical Insurance Information

Initials _____

I/We hereby do ___ do not ___ authorize the release of any medical insurance information necessary to process any insurance claims regarding the Student, to IES and to the medical providers.

Name of Policy Holder _____ Signature of Policy Holder _____

I/We hereby do ___ do not ___ authorize the release of mental health records to the policy holder's insurance company and/or managed care provider for the sole purpose of claims submission and/or possible insurance reimbursement.

Name of Policy Holder _____ Signature of Policy Holder _____

Physical Exams

Initials _____

A physical exam of the Student must have been completed within thirty (30) days prior to admission. If a physical exam has not been completed, I/we hereby give consent to IES to arrange for a physical exam of the Student by a licensed medical provider selected by the school. Annual physical exams are required thereafter. I/We will be responsible for all costs related to the initial physical exam and the required lab tests or immunizations, if not performed prior to admission, and for the costs related to annual physical exams.

Prescriptions

Initials _____

I/We hereby authorize IES to purchase all prescription medications needed by the Student through a local preferred provider and I/we assume the financial responsibility for the cost of such prescriptions. Requests for unique pharmacy services may not be honored or may be provided at an additional cost.

Consent to Medical Treatment

Initials _____

I hereby authorize and consent to any medical or surgical diagnosis and/or treatment for the Student as directed by any licensed medical provider authorized to practice medicine in the state wherein such services are provided. Such treatment may include, but not be limited to: physical examination, x-rays, laboratory analysis, scans, inoculations, vaccinations, anesthesia, emergency surgery or hospitalization. Alternative health care will not be arranged for a student unless prescribed by a licensed medical provider.

Consent to Mental Health Care

Initials _____

I hereby authorize and consent to mental health care provided to the Student by, or under the supervision of, licensed mental health providers employed by IES. The cost of the IES mental health care is included in the cost of the school/program. I consent to an initial clinical assessment of the Student to evaluate the Student's mental health status and/or current psychological needs. I understand that the Student will participate in individual and group therapy and that the mental health status of the Student may be shared with other IES personnel working with the student on an as-needed basis at the discretion of the clinician. If mental health care is required that cannot be provided by IES employees, it will be provided to the Student at the parent's expense by mental health care professionals licensed to provide mental health services in the state wherein such services are provided.

Dental Exams

Initials _____

A dental exam of the Student must have been completed within nine (9) months prior to admission or a dental exam must be done within three (3) months of admission. If a dental exam has not been completed, I/we hereby give consent to IES to arrange for a dental exam of the Student by a dentist selected by the school. Annual dental exams are required thereafter. I/We will be responsible for all costs related to the initial dental exam, if not performed prior to admission, and for the costs related to annual dental exams.

Consent to Dental Treatment

Initials _____

I hereby authorize and consent to any dental or oral surgical diagnosis and/or treatment for the Student as directed by any dentist or oral surgeon licensed to practice dentistry or surgery in the state wherein services are provided. Such treatment may include, but not be limited to: dental examination, x-rays, inoculations, anesthesia, temporary or permanent prosthetic devices or emergency surgery.

Medical Evacuation

Initials _____

In the event of a medical emergency while the Student is engaged in an adventure and/or outdoor experience on public lands, government authorities may be contacted, and IES will abide by their decisions as to any emergency medical evacuation. It is understood that various government entities react in varying ways, and that IES must abide

by their directions in accordance with the rules and regulations that govern IES's use of public lands. I/We will bear the costs and consequences of any decision by one of these government entities in the evacuation of the Student.

Urgent Transfer Agreement

Initials _____

In the event that a temporary transfer of the Student is deemed necessary by IES for either physical, emotional or mental health reasons, I/we hereby authorize IES to transfer the Student to an appropriate interim care facility, licensed medical facility or mental health facility for a period not to exceed three (3) days and agree to accept the financial responsibility for the cost of such temporary services.

Government Services for Runaways

Initials _____

In the event that the Student runs away, government authorities shall be contacted and IES will abide by their decision as to any search and rescue efforts, apprehension and detention of the Student. It is understood that various government entities react in varying ways, and that IES must abide by their directions. I/We will bear the costs and consequences of any decision by one of these government entities.

Authorization for Restraint

Initials _____

I/We hereby give authority and consent to IES personnel to utilize reasonable force to restrain, control and detain the Student only when there is an imminent risk of the Student harming himself or herself or others including IES personnel or is causing serious property damage.

Authorization for Search

Initials _____

I/We hereby give consent and authorize IES to search the Student and the Student's personal effects. IES is hereby authorized to confiscate any and all items deemed by IES to be contraband.

Transportation Consent and Release

Initials _____

I/We hereby authorize IES, at its sole discretion, to place the Student on a public carrier (i.e. airplane, train, bus, etc.) or a private or corporate vehicle for the purpose of transporting him/her to and from IES and to or from IES programs or activities on either public or private lands. I/We hereby release and discharge IES and its officers, directors, shareholders, employees and agents from any and all claims, demands, actions, suits or proceedings which the Student or any parent, relative, or next of kin of the Student, may have for any and all injuries, damages and expenses, including, but not limited to, all personal injuries and illnesses and all damages to personal and real property, caused by, arising out of, or otherwise related to the transportation of the Student, except to the extent such injury or damage results from the gross negligence or willful misconduct of IES or its authorized agents.

Activity Consent and Release

Initials _____

IES schools/programs include academics, emotional growth training, clinical services, general athletic activities, vocational training, a farm program, and numerous activities held both on and off campus including but not limited to: downhill skiing, cross country skiing, camping, rock climbing, canoeing, kayaking, rafting, horseback riding, bicycling, swimming, Alpine Tower, high ropes course, hiking and snowshoeing. I/We hereby consent to the Student's participation in all activities and programs conducted by IES. I/We hereby voluntarily release and discharge IES and its officers, directors, shareholders, employees and agents from any and all claims, demands, actions, suits or proceedings which the Student or any parent, relative, or next of kin of the Student, may have for any and all injuries, damages and expenses, including, but not limited to, all personal injuries and illnesses and all damages to personal and real property, caused by, arising out of, or otherwise related to the Student's participation in any activity or program conducted by or on behalf of IES, except to the extent such injury or damage results from the gross negligence or willful misconduct of IES or its authorized agents.

Media Release

Initials _____

I/We do ___ do not ___ grant permission to IES to use the Student's photograph and/or written work and/or voice in company newsletters, newspapers, brochures, videos, web site or other related promotional materials.

Document Release Within IES

Initials _____

I/We hereby authorize and consent to the release and exchange of all documents and information between IES entities regarding the Student.

Consent to Communicate via E-Mail

Initials _____

I/We hereby consent and authorize IES to send me information concerning the Student's status and activities via e-mail. Because of the privacy limitations inherent in sending information by e-mail, IES will not send any information by e-mail relating to sensitive medical or mental health information.

Outcome Study Consent

Background. In an effort to continuously monitor and improve the services provide by IES, IES asks that both parent/guardians and student/participants be involved in outcome studies that measure the efficacy of the IES programs. The surveys may be taken at the beginning of the program, at the end of the program and at various annual intervals following completion of the program. The student/participant may be asked to participate in a psychological assessment at no cost to the parent/guardian in addition to completion of the survey. Alumni parent/guardians and student/participants may be asked to complete the surveys in writing or by phone. The outcome study results may be published or used in marketing materials by IES. All survey information will be anonymous and no individual names or other specific individual identifying materials will be disclosed.

Consent to Psychological Assessment

Initials _____

I/we hereby authorize and consent to a psychological assessment for the Student as part of an outcome study at no cost to me. Such assessment shall be provided by a Clinical Social Worker, Marriage and Family Therapist or Psychologist licensed to provide clinical services in the state wherein such services are provided. Such assessment may include a face-to-face interview and may also include written assessments and will be utilized by IES for the purpose of an outcome study. There shall be no specific identification of the Student in the outcome study.

Consent to Participate in the Outcome Survey

Initials _____

I hereby authorize and consent for the Student and myself to participate in any outcome study or survey conducted by IES and agrees to be contacted in writing or by phone to complete the ongoing outcome surveys. The Student and I will not be specifically identified in any manner in the publishing of the results of the outcome study or survey materials.

I/We, the undersigned, have read and understand all the consents, releases and authorizations set forth above, initialed them and execute them voluntarily.

Parent/Guardian Name _____ Signature _____ Date _____

Parent/Guardian Name _____ Signature _____ Date _____

MEDICAL HISTORY

Is the student currently on any medications? Yes ___ No ___ (If yes, please list medications and dosage)

Medication	Dosage/Schedule	Purpose of Medication	Prescribed By
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Student should arrive for admission with a 60 day supply of current medications and copies of current refillable prescriptions for such medications. Please do not send vitamins, herbs or food supplements as the nurses will not dispense them unless prescribed by a doctor. Multi-vitamins are available and may be dispensed to a student at the request of the parents/guardians.

Please describe medication history _____

Does the student wear glasses? Yes ___ No ___ Does the student wear contacts? Yes ___ No ___

If yes, please attach glasses and/or contact lens prescription.

Does the student have any allergies? Yes ___ No ___ Is the student allergic to any of the following?

Penicillin ___ Sulfa drugs ___ Iodine ___ Aspirin ___ Other drugs ___ (If yes, please describe) _____

Bee/wasp/hornet sting ___ Does student require a kit? Yes ___ No ___

Food or other allergies (If any, please describe) _____

Other reactions (hives, hay fever, eczema, asthma, etc.) (If any, please describe) _____

Has the student ever been hospitalized? Yes ___ No ___ Reason _____

Date _____ Hospital _____ Attending Physician _____

Does the student wear dentures? Yes ___ No ___ Braces? Yes ___ No ___ Retainers? Yes ___ No ___

(If yes, please describe required usage) _____

Has the student experienced any of the following?

Bed wetting /Age _____ Nail biting /Age _____ Nightmares /Age _____ Stuttering /Age _____

Tics/Age _____ Encopresis/Age _____ Head banging /Age _____

Other (Explain) _____

Has the student been diagnosed with any of the following? (Please list age of occurrence next to condition.)

- | | | |
|-----------------------------------|--------------------------------|------------------------------------|
| Anemia _____ | Frostbite _____ | Obesity _____ |
| Anorexia Nervosa _____ | German Measles _____ | Pneumonia _____ |
| Arthritis _____ | Gonorrhea _____ | Polio _____ |
| Asthma _____ | Hearing loss _____ | Poor Circulation/Extremities _____ |
| Bladder or Kidney Infection _____ | Heart Disorder _____ | Pregnancy _____ |
| Bleeding Disorder _____ | Heart Murmur _____ | Problem with Joints _____ |
| Bone Condition _____ | Hepatitis A _____ | Red Measles _____ |
| Bronchitis _____ | Hepatitis B _____ | Rheumatic Fever _____ |
| Bulimia _____ | Hepatitis C _____ | Scarlet Fever _____ |
| Chicken Pox _____ | Herpes _____ | Sclerosis _____ |
| Constipation _____ | High Blood Pressure _____ | Scoliosis _____ |
| Convulsions _____ | HIV Positive/AIDS _____ | Seizure Disorder _____ |
| Dermatitis _____ | Meningitis, Encephalitis _____ | Sickle Cell Trait _____ |
| Diabetes _____ | Mononucleosis _____ | Syphilis _____ |
| Frequent Colds/Sore Throats _____ | Mumps _____ | Ulcers _____ |
| Frequent Diarrhea _____ | Muscle Weakness _____ | Whooping Cough _____ |
| Frequent Ear Infections _____ | | |

Have any of the student's close relatives ever had any of the following conditions?

<u>Condition</u>	<u>Relation to Student</u>
Bleeding Disorder	Yes ___ No ___ _____
Cancer	Yes ___ No ___ _____
Cardiovascular Disease	Yes ___ No ___ _____
Diabetes	Yes ___ No ___ _____
Epilepsy or Convulsions	Yes ___ No ___ _____
High Blood Pressure	Yes ___ No ___ _____
Kidney Disease	Yes ___ No ___ _____
Mental Disorder	Yes ___ No ___ _____

Muscle Disorder Yes ___ No ___ _____
Tuberculosis Yes ___ No ___ _____
Any other familial illness (Describe) _____

Has the student ever had surgery? Yes ___ No ___
Date _____ Hospital _____ Attending Physician _____
Explain _____

Has the student ever broken a bone? Yes ___ No ___
Please Describe _____
Date _____ Hospital _____ Attending Physician _____

Has the student had any other serious injuries? Yes ___ No ___
Injuries _____
Date _____ Hospital _____ Attending Physician _____

List and explain any excessive fears the student has had (darkness, thunder, death, etc.) and at what age these fears were experienced. _____

Does the student have a drug or alcohol abuse problem? Yes ___ No ___ Previous treatment? Yes ___ No ___
Facility _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____

What known substances has student used and/or experimented _____

Please list any other pertinent medical information not previously listed and any other important information relating to the health history of the student. _____

Don't forget to attach to this application a complete copy of the student's immunization record.

Medical Health Care Providers

Physician's Name _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____ Date of Last Exam _____

Optometrist's/Ophthalmologist's Name _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____ Date of Last Exam _____

Dentist's Name _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____ Date of Last Exam _____

A student must have had a dental exam within the last nine (9) months or have one done within three (3) months of admission. A record of the latest dental exam should be submitted with this application.

Orthodontist's Name _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____ Date of Last Exam _____

Medical and Dental Insurance Information

Proof of medical and dental insurance must be provided in the spaces below prior to a student's enrollment.

Please provide a photocopy of the front and back of your medical and dental insurance cards.

Medical Insurance

Insurance Company _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____
Policy Holder _____ Policy Holder's Social Security No. _____
Policy Holder's Date of Birth _____
Policy No. _____ Group No. (If applicable) _____
Employer (If group policy) _____
Coverage (Emergency, mental health, etc.) _____
Pharmacy Card No. _____ Pharmacy Deductible _____
Signature of Policyholder _____ Date _____

Dental Insurance

Insurance Company _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Fax _____
Policy Holder _____ Policy Holder's Social Security No. _____
Policy Holder's Date of Birth _____
Policy No. _____ Group No. (If applicable) _____
Employer (If group policy) _____
Coverage (Emergency, preventative, cosmetic, etc.) _____
Signature of Policyholder _____ Date _____

Application information provided by (please print) _____

I/We, the undersigned, certify that the information set forth in this Admissions Application is true and correct to the best of our knowledge.

Parent/Guardian Name _____ Signature _____ Date _____

Parent/Guardian Name _____ Signature _____ Date _____

PHYSICAL EXAMINATION

This portion of the application must be completed by a licensed medical provider and returned with test results. The examination must be completed within 30 days of admission.

Student Name: _____ DOB: _____ Date of Exam: _____

Height: _____ Weight: _____ Blood Pressure: _____ / _____ Pulse: _____

Head: _____

Eyes: _____ Right: _____ / _____ Left: _____ / _____ Glasses/Contacts Yes ___ No ___

Ears: _____ Whisper Hearing Test: _____

Nose/Throat: _____ Neck/Lymph: _____

Chest: _____ Heart: _____

Abdomen: _____ Neurological: _____

Genitals (if indicated): _____ Hernia: _____

Muscular/Skeletal: _____ Scoliosis: _____

Pelvic (if indicated): _____ Breast (if indicated): _____

Please list all current medical problems under treatment, including current medication and dose:

Please note any physical impairment that would limit ability to participate in activity (include need for substance detoxification): _____

Please list any allergies experienced, including treatment and medication: _____

Required Laboratory Tests:

CBC with Differential	Viral Hepatitis Screen	BMP
HIV Test	TSH-R	LFT's
VDRL	Urinalysis	GC/Chlamydia
Pregnancy	Sickle Cell Trait Screening (if indicated)	

Required Immunizations: (Please attach complete immunization record)

Tuberculosis Skin Test: _____ Results: _____

Tetanus Booster (within 5 years): _____

Significant Findings/Recommendations: _____

Medical Provider

Based on my examination and the medical history, the above named applicant is cleared for: Full participation in outdoor activity (hiking, backpacking activity in cold weather and altitude over 5000 feet). Yes ___ No ___

If limited participation, please note the restrictions: _____

Name: _____ Signature: _____ Date: _____

Address: _____ Phone Number: _____