P.O. Box 384, Reedsburg, WI 53959
800-205-6713 FAX / 608-524-8302

MEDICAL EVALUATION

Must be completed by a Physician, Nurse Practitioner or Physician Assistant

TRAVELER'S NAME: ______________________ **Date of exam:** __________

Address: ______________________ Date of birth: __________

City: __________ State: ______ Zip: ______ Male _____ Female _____

Phone: (_______)______________________ Trip Title: __________

Medical Diagnosis: ______________________

Height ______ Weight ______ BP ______ T ______ P ______ R ______

Is the following normal? If no, explain:

1. Ears ______
2. Nose ______
3. Throat ______
4. Skin ______
5. Eyes ______
6. Scalp ______
7. Heart ______
8. Lungs ______
9. Extremities ______
10. Glands ______
11. Abdomen ______
12. Varicosities ______
13. Genitalia ______

Is there a history of? If yes, explain:

1. Asthma ______
2. Hernia ______
3. Enuresis ______
4. Recent Fevers ______
5. Recent Weight Loss ______
6. Kidney Disease ______
7. Diabetes ______
8. Stomach Disorders ______
9. Frequent Colds/Hay Fever ______
10. Hepatitis ______
11. Heart Disease ______
12. Previous surgery ______
13. Neurologic ______

14. TB or Contact w/TB+ individual? Y / N • TB tested Y / N • If yes, test date & results. ______
15. Other – explain ______

Does this person have seizures or convulsions? ______ If yes, frequency ______

Type ______ Last seizure ______

Any Blood/Body Fluid precaution? Y N • If yes, type: ______

Will this person require medication while on an Able Trek Tours trip? ____ Yes ____ No If yes, complete below:

Name of Medication	Dosage	Time/Frequency given	Reason for Medication

May this person be given these OTC medications if the need arises?

	Yes	No		Yes	No
Pepto Bismol	_____	_____	Loperamide	_____	_____
Kaopectate	_____	_____	Decongestant	_____	_____
Milk of Magnesia	_____	_____	Cough Syrup	_____	_____
Fleets enema	_____	_____	Aspirin	_____	_____
Antacid	_____	_____	Tylenol	_____	_____
			Dramamine	_____	_____

Does this person have any physical disabilities? ____ Yes ____ No If so, please describe: ______________

____

Does this person use any special equipment (wheelchair, walker, hearing aid, dentures, etc.) _________________

____

Does this person have any allergies? ____ Yes ____ No If so, please describe: ____________________

____

Has this person been immunizes against the following and when? Tetanus _____ Yes (date) ________ No____
Polio _____ Yes (date) ________ No ___

If not immunized for tetanus in the past 10 years, please do so prior to the scheduled trip.

RESRTICTIONS: Please explain

Diet: ____

Swimming: ____

Strenuous Exercise: ____

Hiking/walking long distances: ____

Other restrictions: ____

ANY FURTHER RECOMMENDATIONS: ____

____

____

____

Signature of Physician, NP or PA: _______________________________________ Date: _______________

Please print name: ______________________________ **Date of exam:** ___________ Phone: (____)____________

This form must be returned to Able Trek Tours at least 21 days before the trip departure date. The evaluation must be completed by a medical physician within 12 months of the trip departure date. If either of the above requirements is not met, the Traveler becomes ineligible for Able Trek Tours trips. These requirements help insure proper health care is given by our staff.

Traveler's medications MUST be individually pre-packaged according to the time and date of each dispensing. DO NOT pack medications in suitcases. All medications, unless the Traveler self-medicates, will be given to the Tour Director or person responsible for dispensing them at the time of check-in.

Mail/fax all medical forms at least 21 days prior to the trip departure date to:

Able Trek TOURS

P.O. Box 384, Reedsburg, WI 53959

608-524-3021 800-205-6713 FAX / 608-524-8302