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 TB tested, 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
			Loperamide	_____	_____
Pepto Bismol	_____	_____	Decongestant	_____	_____
Kaopectate	_____	_____	Cough Syrup	_____	_____
Milk of Magnesia	_____	_____	Aspirin	_____	_____
Ibuprofen	_____	_____	Tylenol	_____	_____
Antacid	_____	_____	Dramamine	_____	_____

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

____

Can this person ambulate independently? ____ Yes ____ No If not, please describe: ____________________

____

Can this person transfer self independently without assistance? ____ Yes ____ No

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 immunized against the following and when? **Tetanus** ___ Yes (date) _________ ___ No
Influenza ___ Yes (date) _________ ___ No **Polio** ___ Yes (date) _________ ___ No
Covid-19 Y / N - If YES: Date of immunization(s) 1st ___/___/___ 2nd ___/___/___ 3rd ___/___/___

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

RESRTICTIONS: Please explain

Diet: ____

Pool/hot tub: ____

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 ensure 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 staff@abletrektours.com