



P.O. Box 384, Reedsburg, WI 53959
 800-205-6713 FAX / 608-524-8302
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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 _____
14. TB or contact w/TB+ individual? Y / N • TB tested? Y / N • If TB tested, date & results. _____
15. Other – explain _____

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 _____

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:
 or attach medication list.

| <u>Name of Medication</u> | <u>Dosage</u> | <u>Time/Frequency given</u> | <u>Reason for Medication</u> |
|---------------------------|---------------|-----------------------------|------------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

| | | | |
|--------------------------------------------------------------------|-------|-------|--------------------|
| 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 _____ |
| Dramamine | _____ | _____ | Aspirin _____ |
| Antacid | _____ | _____ | Tylenol _____ |
| | | | Ibuprofen _____ |

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 | <input type="checkbox"/> Yes (date) _____ | <input type="checkbox"/> No |
| Influenza | <input type="checkbox"/> Yes (date) _____ | <input type="checkbox"/> No |
| Polio | <input type="checkbox"/> Yes (date) _____ | <input type="checkbox"/> No |

COVID 19 Y / N Immunization date(s) 1st ___/___/___ 2nd ___/___/___ 3rd ___/___/___ 4th ___/___/___

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

RESTRICTIONS: 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. A medical evaluation must be completed by a medical physician, PA or NP 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 suitcase. All medications, even if the Traveler self-medicates, must 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
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