Able Trek TOURS
P.O. Box 384, Reedsburg, WI 53959
608-253-0241
staff@abletrektours.com

Document to be returned via mail or email

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: or attach medication list.

Name of Medication	Dosage	Time/Frequency given	Reason for Medication

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

	Yes	No
Pepto Bismol	_____	_____
Tylenol	_____	_____
Dramamine	_____	_____
Ibuprofen	_____	_____
Meclizine	_____	_____
Benadryl	_____	_____
Loperamide	_____	_____

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 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.*

RESRTICTIONS: Please explain

Diet: _____

Pool/hot tub: _____

Strenuous Exercise: _____

Hiking/walking long distances: _____

Other restrictions: _____

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 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 if the traveler is not self medicating.

Mail/Email all medical forms no later than the pay in full date listed on website / in book

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