

Health Form

All AMGCSI guests must have this form filled out by your physician, F.N.P., or P.A. in order to participate in one of our trips.

_____		_____	
Guest's Name		Trip Name	
_____		_____	
()		()	
Daytime or Temporary Phone (circle one)		Permanent Phone	

Gender	Age	Date	

AMGCSI Expedition Information for the Medical Professional

Alaska Mountain Guides and Climbing School Inc. (AMGCSI) trips are wilderness expeditions, varying in length from five days to three months. AMGCSI expeditions operate in remote areas where evacuation to modern medical facilities may take days.

Weather conditions can be extreme with temperatures ranging from -40 F to +100 F. Prolonged storms, high winds, intense sunlight, sudden immersion in cold water and/or high seas are possible.

Physical demands on the applicant may include carrying a backpack weighing between 55-85 pounds over uneven terrain such as snow, rocks, boulders, fallen logs, or slippery surfaces as well as ascending and descending steep mountain slopes. Elevations may vary and specific trips/courses may reach up to 23,000ft. Physical demands of sea kayaking and river courses require paddling heavily loaded kayaks, canoes or rafts and lifting and carrying boats over uneven terrain.

While participating on an AMGCSI expedition, students will sleep outdoors, experience long physically demanding days, set up their own camp and prepare their own meals. Each participant is expected to take good care of him or herself.

AMGCSI is not a rehabilitation program. AMGCSI is not the place to quite smoking, drinking or drugs or to work through behavioral or psychological problems.

Prior physical conditioning and an enthusiastic mental attitude are a necessity. Guests find an AMGCSI trip to be extremely demanding experiences both physically and emotionally.

In the interest of the personal safety of both the participant and the other expedition members, please consider the questions carefully when completing the health form. A "Yes" answer does not automatically cancel a guest's enrollment. If we have any questions on the guest's capacity to successfully complete the trip we will call the guest to discuss it.

All guests are REQUIRED to bring the following medications:

1 course of broad-spectrum antibiotics that is effective for upper respiratory problems.

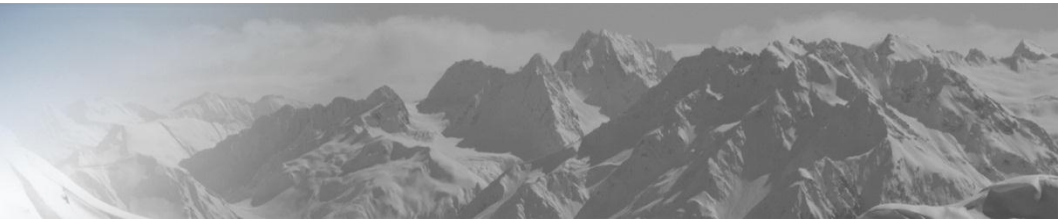
1 course of broad-spectrum antibiotics that is effective for GI problems.

Guests on courses going about 15,000ft or 4,200m are also REQUIRED to have the following high altitude medications: Acetazolamide (Diamox) and Dexamethasone (Decadron). Also, Nifedipine (Procardia) is optional.

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Physician, F.N.P. or P.A.:

Please check YES or NO for each item. Each question must be answered and please **provide date and details for all "yes" answers.**

General Medical History

Does this person currently have a history of:

- | | | |
|--|-----|----|
| 1. Respiratory problems? Asthma? | YES | NO |
| Is the asthma well controlled with an inhaler? | YES | NO |

If so, please have the guest bring inhaler(s) with them for their course.

What triggers an attack? Last episode? Ever hospitalized? _____

- | | | |
|-----------------------------------|-----|----|
| 2. Gastrointestinal disturbances? | YES | NO |
| 3. Diabetes? | YES | NO |

Examiner's specific comments: _____

- | | | |
|---|-----|----|
| 4. Bleeding, DVT (deep vein thrombosis) or blood disorders? | YES | NO |
| 5. Hepatitis or other liver disease? | YES | NO |

Examiner's specific comments: _____

- | | | |
|--|-----|----|
| 6. Neurological problems? Epilepsy? | YES | NO |
| 7. Seizures? | YES | NO |
| 8. Dizziness or fainting episodes? | YES | NO |
| 9. Migraines? Medications, frequency, are they debilitating? | YES | NO |

6-9. Describe frequency, date of last episode, and severity. ? _____

- | | | |
|--|-----|----|
| 10. Disorders of the urinary or reproductive tract? | YES | NO |
| 11. Any disease? | YES | NO |
| 12. Does this person see a medical or physical specialist of any kind? | YES | NO |

IF "yes" please specify the issue(s) and provide name/address of specialist. _____

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Questions 13 and 14 are for Female Guests Only:

13. Treatment or medication for menstrual cramps? YES NO
 14. Is she pregnant? YES NO
 Examiner's specific comments: _____

15. Hypertension? YES NO
 16. Cardiac problems? Unexplained chest pain? YES NO
 Examiner's specific comments: _____

Cardiac Screening:

A stress ECG is required if the applicant is:	Cardiac Risk Factors
1. Over 35 years old and has 2 cardiac risk factors. 2. Over 50 years old and has 1 cardiac risk factor. 3. Over 50 years old and leads a sedentary lifestyle. 4. Any age with a known heart condition. Please provide a written note from your doctor stating the date of the stress ECG and the results	<ul style="list-style-type: none"> • High blood pressure • Diabetes • Current or prior cardiovascular disease • High blood cholesterol • Family history of heart disease (family member who's had a heart attack at less than 55 years of age.) • Smoking

The stress ECG requirement may be waived for applicants who are over 50 years of age with no cardiac risk factors and who are in good physical condition. **Their physician must note that the participant has a) no cardiac risk factors and b) excellent cardiac health on page 6 of this form.**

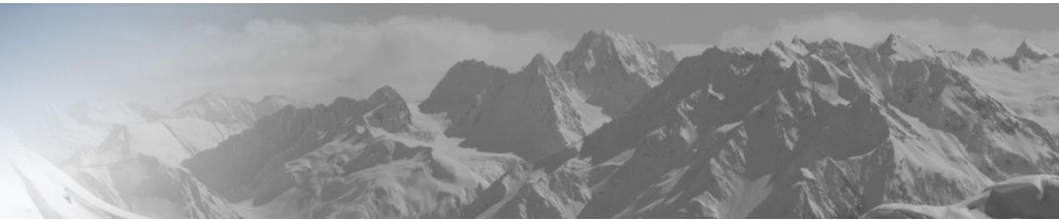
Muscle/Skeletal Injuries/Fractures

Does this person currently have or does he/she have a history within the past 3 years of:
 17. Knee, hip or ankle injuries (including sprains) and/or surgery? YES NO
 Type of injury or surgery? When did the injury or surgery occur? _____

Is there full ROM? Full Strength? YES NO
 What is the most rigorous activity participated in since the injury/surgery. Results? _____

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Examiner's specific comments: (include date of last occurrence and the effect of the problem on current activity level) _____

18. Shoulder, arm or back injuries (including sprains) and/or surgery? YES NO
 Type of injury or surgery? When did the injury or surgery occur? _____

Is there full ROM? Full Strength? YES NO
 What is the most rigorous activity participated in since the injury/surgery. Results? _____

Examiner's specific comments: (include date of last occurrence and the effect of the problem on current activity level): _____

19. Any other joint problems?
 Examiner's specific comments: (include date of last occurrence and the effect of the problem on current activity level): _____

20. Head Injury? Loss of consciousness? For how long? YES NO
 Examiner's specific comments: (include date of last occurrence and the effect of the problem on current activity level): _____

21. Does this person have any physical, cognitive, sensory, or emotional condition that would require a special teaching environment? YES NO
 If yes, please describe how the condition effects you: _____

Personal History (Counseling/Psychiatric/Learning Disabilities)
 AMG requires that any participant with a counseling history demanding medication, hospitalization or residential treatment, display one year of stability before they will be accepted for a course. They must be successfully employed or in school.

22. Has he/she had treatment, counseling or hospitalization with a mental health professional? YES NO
 23. Is he/she currently in treatment or counseling? YES NO

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24. Reasons for treatment or counseling? (please circle)

- suicide
- substance abuse/chemical dependency
- eating disorder (anorexia/bulimia)
- academic/career

- ADD/ADHD
- family issues/divorce
- depression
- other _____

Please provide Specific Dates and Details of Counseling Hx and medications that were provided:

25. Name, address and telephone number of therapist?

Allergies

26. Is he/she allergic to any foods? YES NO

Describe: _____

27. Are there any dietary restrictions? Please specify YES NO
 vegetarian vegan other

28. Allergic to insect bites or bee stings? YES NO
 If appropriate please bring 2-3 Epi Pens or Twinjects.

Examiner's specific comments: _____

29. Any other allergies? YES NO

Examiners Specific comments: _____

30. Water may be disinfected with iodine. Is iodine contraindicated? YES NO

Medications

31. Is he/she allergic to any medications? YES NO

If yes, please list: _____

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32. Does this person plan to take any prescription or non-prescription medications on the course?
 YES NO

AMGCSI trips travel in remote areas where access to medical care may be one or more days away. The guest must understand the use of any prescription medications they may be taking. Written specific instructions are necessary. All guests who are required by their personal physician, psychiatrist or health care provider to take prescription medications on a regular basis must be able to do so on their own and without additional supervision.

Medication	Dosage	Side Effects/Restrictions	Prescribed by?	For what Conditions?

If Medication or Condition Changes Prior to Trip Start, Please inform AMGCSI.

Field staff may administer the following over the counter medications at the appropriate dosage if a guest indicates the need for a particular medication (other medications may apply as appropriate). Please indicate if guest has any allergies or contraindications to the following medications.

Aspirin, Acetaminophen, Ibuprofen, Psuedoephedrine, Diphenhydramine, Pepto Bismol, Imodium, Tolnaftate (external only)
 Monistat-1, Orobace, Cavit, Activated Charcoal

Field staff may administer the following prescription medications and their appropriate dosage if a guest indicates the need for a particular medication (other medications may apply as appropriate). Administration of these medications will be checked off by the AMGCSI medical director. Please indicate if the guest has any allergies or contraindications to the following medications.

Ciproflaxin , Azythromax, Ultram, Nifidipene, Acetozolamide, Dexamethasone.

Cold, Heat, Altitude

33. History of frostbite or Raynaud's Syndrome? YES NO

34. History of acute mountain sickness, high altitude pulmonary/cerebral edema? YES NO

When did the illness occur? _____

35. History of heat stroke or other heat related illness? YES NO

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Examiner's specific comments: _____

Fitness (please provide details concerning the participants exercise regime)

36. Does the applicant exercise regularly? YES NO

Activity _____ Frequency _____
 _____ Duration/Distance _____ Intensity Level: Easy Moderate
 Competitive

Activity _____ Frequency _____
 _____ Duration/Distance _____ Intensity Level: Easy Moderate
 Competitive

37. Is this person overweight? Underweight? If so how much? _____ YES NO

38. Swimming ability (CHECK ONE): Non-swimmer Recreational Competitive

Physical examination

Physician must read and fill out pages 1-6. **Physical examination data cannot be more than a year old from the starting date of the AMGCSI trip.** (Please type or print legibly)

AMGCSI Requires a Tetanus Immunization Within 10 Years of the Start Date of the trip.

Exceptions Outside the U.S. May Require Additional Immunizations. Please refer to your course description for specific information.

_____ _____ _____ _____ _____
 Blood Pressure Pulse Last Tetanus Inoculation Height Weight

General Appearance, Impressions and Comments: (If applicable, address cardiac health. See Question #16.):

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Examiner's Name () _____
Phone

Street Address State Zip

Physician, F.N.P. or P.A. Signature Date

By my signature, I attest that the information in this form is correct and the person named on page one of this form is medically cleared to participate on an AMGCSI trip based on the expedition information provided on page 1 of this form along with the background information provided by this person and my physical examination of him/her. Additionally, I have reviewed the medications that AMGCSI carries in the field and noted any exceptions.

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