RETURN

PHYSICIAN'S EXAM – FINS PROGRAM

To the Physician, Licensed Nurse Practitioner, or Physician's Assistant:

You are being asked to consult on this applicant because we want them to have a safe and healthy experience. These courses contain elements of significant physical stress requiring more strength and endurance than most individuals ordinarily encounter. Your patient may be involved in activities such as:

- **Immersion in cold water**
- **Portaging 70 lb. canoe, up to several miles, across rough terrain**
- **Running on uneven ground**
- **Participating in a ropes course—extreme heights**
- **Canoeing for 8+ hours at a time**
- **Remote wilderness setting**

We have found that people who are in overall good health with average physical ability can successfully complete the program. However, because the programs often take the participants to remote areas where quick access to medical facilities may be delayed for 8 hours or longer, prevention of serious health hazards becomes paramount. We appreciate your help—your assessment of this patient and our knowledge of the course elements will allow us to make an accurate medical screening decision. Thank you!

A. VITAL SIGNS/STATISTICS

Information must be based upon examination done within six months of course start date.

Patient's Name: _____

Height: _____ ft. _____ inches Weight _____ lbs.

BMI _____ Please indicate if the patient is over or underweight:

Overweight by _____ lbs, Underweight by _____ lbs.

Blood Pressure: _____/_____

If BP is over 150/90, please repeat:

Second Reading: _____/_____

Pulse Irregularities: ❑ Yes ❑ No - If yes, please describe symptoms and indicate clinical significance:

_____

B. PHYSICIAN'S EXAM

Information must be based upon examination done within six months of course start date. Check box if normal; describe if abnormal.

❑ Eyes/Ears

_____

❑ Nose _____

❑ Throat/Mouth

_____

❑ Lymph Nodes

_____

❑ Thorax/Lungs

_____

❑ CNS _____

❑ Thyroid _____

❑ Heart _____

❑ Heart Murmur

_____

❑ If Murmur, functional

_____

❑ Abdomen _____

❑ Hernia _____

❑ Peripheral Vessels

_____

❑ Neck _____

❑ Back _____

❑ Shoulders _____

❑ Knees _____

❑ Ankles/Feet

_____

❑ Extremities

_____

❑ Skin _____

❑ Other _____

RETURN

Check if the patient is diagnosed with any of the following conditions. If so, indicate if the condition is controlled/stable.

❑ Allergies - food _____

❑ Allergies – other _____

❑ Asthma _____

❑ Seizures _____

❑ Hypertension _____

❑ High Cholesterol _____

❑ Diabetes _____

❑ Other _____

C. SUMMARY OF ACTIVE MEDICAL PROBLEMS AND/OR RESTRICTIONS ❑ NONE (or list below)

_____

_____

_____

_____

_____

D. IMMUNIZATION

We recommend that all of our participants have a current tetanus immunization (within 10 years).

E. KNOWN MEDICATIONS If any please list. ❑ NONE (or list below)

Medication List Below	**Taken For** Symptom/Condition	**Dosage** Size/Frequency	**Date Started**	**Current Side Effects** (if any)

F. ADDITIONAL COMMENTS ❑ NONE (or list below)

_____

_____

_____

_____

_____

G. PHYSICIAN'S SIGNATURE

Please check one of the following boxes. The patient is cleared to participate in physical activity:

- ☐ Without restriction
- ☐ With the following restriction(s): _____
- ☐ Contingent upon follow up (please specify what follow up is required):

_____

How long have you known the applicant? _____

Physician's Name (print): _____

Physician's Signature: _____

Date of Exam: _____ Must be within 6 months of start date.

Telephone: _____ **FAX:** _____

Email: _____