



The Mountain Guide School Health and Lifestyle Form

Participants, please provide the following information:

Full Name	Course Name and Dates
Date of Birth (Day/Month/Year)	Email Address
Home Phone	Work Phone
Height	Weight
Gender	Shoe Size (US, UK, Euro)
Health Insurance Company	Policy Number
Health Insurance Company Phone	Health Insurance Company Address
Travel Insurance Company	Policy Number
Travel Insurance Company Phone	Travel Insurance Company Address
Primary Emergency Contact Name	Relationship
Primary Contact Home Phone	Primary Contact Work Phone
Primary Contact Cell Phone	Primary Contact Email Address
Secondary Emergency Contact Name	Relationship
Secondary Contact Home Phone	Secondary Contact Work Phone
Secondary Contact Cell Phone	Secondary Contact Email Address



The Patagonia Mountaineering School Health and Lifestyle Form

For the Medical Professional:

Participant's Name _____

Date of Birth (Day/Month/Year) _____

Dear Medical Professional,

Greetings from Patagonia and thank you very much for taking the time to fill out this form in detail. Before undertaking this demanding course, we feel it is important that each of our course participants consults with a doctor to discuss their relevant medical history. To help you make an accurate assessment of the individual's ability to participate in the this trip, we have provided you with information about what the trip entails below

The Mountain Guide School mountain guide training to students wishing to work in the guiding industry. The course totals two years in length, with classes running 21 and 42 days. We operate in remote Patagonia and Alaska, where access to medical care may take days, and the overall standard of medical care may be lower that found at home.

In both locations, the weather is often extreme, with temperatures ranging between -25• F and 100• F (-32• C and 35• C). We often experience prolonged storms, high winds, intense sun. Sudden immersion in cold water is possible.

In addition to the weather, the physical demands placed on the participant include carrying a 50 to 80 lbs (25 to 40 Kg) backpack over uneven terrain such as snow, ice, rocks, boulders, logs, or on slippery surfaces, as well as ascending and descending steep slopes. Elevations for the expedition may be as great as 14,000 ft (4000m). Participants will sleep out doors, experience long, physically demanding days, be responsible for setting up their own camp and cooking their own meals. Participants are expected to take good care of themselves.

Good physical fitness and a good mental attitude are necessary. The expedition will be physically, mentally, and emotionally challenging, and participants need to be ready to meet that challenge.

We are not a rehabilitation program. The mountains are not the place to quit smoking, drinking, or drugs, nor to work through behavior or psychological problems.

In the interest of personal safety for both the participant and other expedition members, please carefully consider the following questions. A "Yes" answer does not automatically disqualify a participant. If we have any questions regarding a participant's ability to complete a course, we will call the participant to discuss it.

Please circle Yes or No for each item. **Each question must be answered and please provide date and details for any Yes answer.**

General Medical History:

Does the participant currently have or have a history of:

Respiratory problems? Asthma?	Yes	No
Is the asthma well controlled with an inhaler?	Yes	No

If so, please ask the student to bring two inhalers with them for their expedition.
What triggers an attack? Last Episode? Ever Hospitalized?

Gastrointestinal Problems?	Yes	No
Diabetes?	Yes	No

Specific Comments:

Bleeding, Deep Vein Thrombosis, or Blood Disorders?	Yes	No
Hepatitis or other Liver Disease?	Yes	No

Specific Comments:

Neurological Problems? Epilepsy?	Yes	No
Seizures?	Yes	No
Dizziness or Fainting Episodes?	Yes	No
Migraines? Are they debilitating?	Yes	No

Describe frequency, date of last episode and severity:

Disorders of the urinary or reproductive tract?	Yes	No
Kidney Disorders?	Yes	No

Specific Comments:

Hypertension?	Yes	No
Cardiac Problems? Unexplained Chest Pain?	Yes	No

Specific Comments:

Any other relevant Disease or Disorder? Yes No
Is the participant seeing a medical specialist of any kind? Yes No
Please specify the issue and provide the name/phone number of the specialist:

For Female Participants:

Treatment or medication for Menstrual Cramps? Yes No
Is she pregnant? Yes No
Specific Comments:

Musculoskeletal Injuries:

Does the participant currently have or have a history of:
Knee, hip, or ankle injuries (including sprains) and/or surgery? Yes No
Specific Comments:

Is there full range of motion? Full strength? Yes No
What is the most rigorous activity participated in since the injury/surgery? Results?:

Specific Comments:

Shoulder, arm, or back injuries (including sprains) and/or surgery? Yes No
Specific Comments:

Is there full range of motion? Full strength? Yes No
What is the most rigorous activity participated in since the injury/surgery? Results?:

Specific Comments:

Any other joint, muscular, or skeletal injuries? Yes No
Specific Comments:

Head injuries or loss of consciousness? For how long? Yes No
Specific Comments:

Does the participant have any physical, cognitive, sensory, or emotional condition that would require special care in the field? Yes No
Specific Comments:

Personal History (Counseling, Psychiatric, Learning Disabilities)

We require that any participant with a counseling history needing medication, hospitalization, or residential treatment display one year of stability, and be successfully employed or in school.

Has the participant had treatment, counseling, or hospitalization with a mental health professional? Yes No
Is he or she currently in treatment or counseling? Yes No
Specific Comments:

Name and telephone number of the therapist:

General Information:

Is the participant allergic to any foods? Yes No
Are there any dietary restrictions (Vegetarian, Gluten Intolerance) Yes No
Specific Comments:

Allergies to insect bites or bee stings? Yes No
If yes, please bring 2-3 Epi-pens or Twin-jects.
Specific Comments:

Any other allergies? Yes No
Specific Comments:

Medications:

Is the participant allergic to any medications? Yes No
Specific Comments:

Is the participant planning to take any prescription or non-prescription medications on the expedition? Yes No

Medication	Dose	Prescribed By?	Why?	Yes	No

Does the participant have a history of frostbite or Reynaud's Syndrome? Yes No
Acute Mountain Sickness, High Altitude Pulmonary/Cerebral Edema? Yes No
Specific Comments:

Heat Stroke or other heat related injury or illness? Yes No
Specific Comments:

Fitness:

Does the participant exercise regularly? Yes No
Please describe activity, duration, frequency, and level (easy, moderate, competition):

Does the participant smoke? How much? _____ Yes No
There is no smoking on our expeditions. We recommend the participant quit now.

Is the participant over or underweight? How much? _____ Yes No

Swimming ability: Non-swimmer Recreational Competition

General Impressions, and any Other Comments:

Blood Pressure

Pulse

Height

Weight

Date of Last Tetanus Shot (Must be within last 10 years)

Examiner's Name

Phone

Street Address

City

State/Province

Country

Postal Code

Date

Physician, Nurse, or PA Signature

By my signature, I attest that the information in this form is correct. Based on the information contained within this form, along with my examination of the participant and the history provided by him or her, the named participant is medically cleared to participate in the course.

Participant, please return all 7 pages of this document to The Mountain Guide School via one of the following methods. Please bring the original document with you:

Email (scan): info@mountainguideschool.com

Fax: +1-763-374-4641

**Mail (photocopy): Benjamin Gorelick
The Mountain Guide School
2012 Costero Hermoso
San Clemente, CA 92673
USA**