# 2024 MEDICAL EVALUATION FORM

***To be completed by a Licensed Healthcare Practitioner | Required for any participant diagnosed with cancer***

**ATTENTION HEALTHCARE PROFESSIONALS:** Your patient will be joining a whitewater adventure program in a wilderness area near Riggins, ID, involving hiking, rafting, camping, and group activities over 3 to 6 days. Each day meets ACS guidelines for 150 minutes of moderate intensity activity. Camping will involve sleeping on camping mattresses in tents on the sand. Participants must be able to rise from a laying position and be able to get themselves in and out of boats with minimal assistance.

A medical evaluation within the past 3 months by a licensed healthcare provider is required. You may attach a copy instead of completing this form, but it must include the practitioner's signature and date. The evaluation is mandatory for participants currently under medical care, on a prescribed diet, with recent injuries or illnesses limiting activity, history of loss of consciousness during physical activity, or concussion from head injury.

Patient Name _____ DOB _____/_____/_____ Age_____

***Review the health history with the participant for any interim changes. Explain any "abnormal" evaluations - attach additional sheets as needed.***

**PHYSICAL EXAMINATION:** *(to be completed by a licensed health-care practitioner)*

Height _____ Weight _____ BP _____/_____ Pulse _____

Oncology Diagnosis: _____ Diagnosis date: _____

Other Medical Conditions/Diagnosis: _____

_____

Medication *(Please list or attach a list of current meds including dose, route, frequency)*: _____

_____

***Please be advised: no electricity is available for the week your patient is attending the program.***

Does this patient use medical equipment daily that requires electricity (CPAP)? _____

Does this patient have any open wounds, stitches, ports/picc lines and drains?_____

If yes to the above questions, please explain. _____

VISION: Normal _____ Glasses _____ Contacts _____

HEARING: Normal _____ Abnormal _____ Explain _____

URINALYSIS: *(when indicated)* Albumin_____ Sugar _____

NEUROPATHY: please explain any challenges or limitations: _____

_____

| **Check Box:** | **Norm** | **Abn** | | **Norm** | **Abn** | | **Norm** | **Abn** |
|---|---|---|---|---|---|---|---|---|
| Growth development | ☐ | ☐ | Teeth | ☐ | ☐ | Genitalia | ☐ | ☐ |
| Skin | ☐ | ☐ | Cardiopulmonary | ☐ | ☐ | Musculoskeletal | ☐ | ☐ |
| HEENT | ☐ | ☐ | Hernia | ☐ | ☐ | Neurobehavioral | ☐ | ☐ |
| Respiratory | ☐ | ☐ | Gastrointestinal | ☐ | ☐ | Integument | ☐ | ☐ |

Explain any abnormal findings: _____

Circle any of the following that apply. Use of: Brace Splint Prosthetic Cane Crutch

Additional information or concerns: _____

_____

Loss of Balance/Coordination _____ Details _____

Previous injury or ailment that may give you trouble occasionally: _____

Circle all the following physical symptoms from cancer patient may be currently experiencing:

Fatigue Nausea Pain Diarrhea Other _____

**Approved for all activities?** *(Hiking, Camping, Whitewater rafting, and vigorous sports)* **Yes** **No**

Activity Restrictions (if any):_____

Diet restrictions _____

Other Issues/Information _____

**Healthcare Professional Name** *(print)* _____ **Phone** _____

**Healthcare Business Name**:_____

**Signature**_____M.D./D.O./N.P/PA-C **Date** _____

Address _____

City, State, Zip _____

If utilizing a stamp please stamp here: