Wyoming Catholic College
Wisdom in God's Country

306 Main Street, Lander, WY 82520
1-307-335-4462
registrar@wyomingcatholic.edu
www.wyomingcatholic.edu

Physical Examination Form

Academic Year 2024-2025

Due by July 1st, 2024

This required form must be filled in by a Physician, Licensed Nurse Practitioner or Physician Assistant during a physical examination of the applicant.

Please use this particular form. A different form will not be accepted.
-This assessment must be done by one of the aforementioned professionals and is required *before* you arrive on campus.
Your participation in this course is dependent upon COR's receipt of this form by July 1.-

The expedition, which is a required course in our curriculum, will include a variety of outdoor recreation activities. The length of the expedition is 21 days. While the activities will be suitable for those of average health and fitness, applicants should be aware of the following:

- **Backpacking w/50-65 lb pack, hours at a time, over rough terrain**. Participants will hike and camp in rocky/mountainous terrain that will include traveling on steep hiking trails, off-trail hiking, crossing fast-flowing streams, and camping in tents in cool overnight temperatures.
- **High altitude hiking/backpacking/mountaineering (physical exertion and living at elevations over 10,000+ feet)**. Students sleep outdoors, experience long days, set up their own camp and cook their own meals.
- **Extreme weather conditions**. Weather conditions may include temperatures ranging from the low 40's to over 100° F. Thunderstorms, strong winds, intense sunlight, and potential sudden immersion in cold water are all possible.
- **Water disinfection**. All wilderness water will be disinfected with iodine, betadine, chlorine dioxide or by boiling. Not all of these methods are effective against cryptosporidium. Immunocompromised people may wish to obtain a certified water filter for the expedition.

In the interest of the personal safety of both the applicant and the other expedition members, please consider the questions carefully when completing this form. Please note that a "Yes" answer does not automatically disqualify an applicant. If we have questions regarding an applicant's ability to successfully complete the course, we will call the applicant to discuss it. We appreciate your assessment of this individual in light of the above course activities and conditions.

Detailed comments will expedite our review of this form. Each question must be answered and please provide details for all "Yes" answers.

Patient Name:_____

Gender: □ Male □ Female Height: _____ Weight: _____ BMI: _____ DOB: _____

Please indicate if the applicant is: □ Overweight or □ Underweight If so, how much? _____

If applicant is overweight or obese, additional requirements may be imposed to prove adequate fitness to complete the expedition.

Pulse irregularities? □ Yes □ No If yes, please describe symptoms and indicate clinical significance: _____

_____

Blood Pressure: _____/_____ If BP is over 150/90, please repeat: Second Reading _____/_____

1. **Physician's Examination**. Information must be based upon examination done within six months of course start date.

√ **if Normal**	√	Describe if Abnormal
Skin		
Eyes		
Peripheral Vision		
Ears		
Nose		
Throat/Mouth/Teeth		
Neck		
Thyroid		
Lungs		
Heart		
Liver		
Abdomen		
Back		
Extremities		
Knees		
Ankles/Feet		
Nervous System		
Muscles, Joints, Bones		
Digestive System		
Urinary Tract		
Reproductive System		

If Female, is the applicant currently pregnant? _____Yes _____No

2. **Patient Health History.** Please check box if applicant has or has a history of any of the following:

√ if patient has this condition	√	Comments. Please note if condition is controlled/stable
Anemia		
Arthritis		
Asthma /Had an Asthma Attack?		
Blood Disorders		
Cancer		
Diabetes		
Dizziness/Fainting Episodes		
Eczema		
Epilepsy/Seizures		
Head Injury/Loss of Consciousness		
Heart Disease/HBP/ High Cholesterol		
Hepatitis or other Liver Disease		
Migraines/Headaches		
Neurological Problems		
Thyroid Disease		
Other		

Is the applicant currently seeing a medical or physical specialist of any kind? _____ Yes _____ No

If Yes, please explain:

_____
_____
_____
_____
_____
_____
_____

3. **Patient Mental Health History.** Please check box if applicant has or has a history of, and/or received therapy/counseling for any of the following:

√ **if patient has this condition**	√	Comments: Severity, frequency, treatment, stability, etc.
Academic/Career Difficulties		
ADD/ADHD		
Anxiety		
Depression		
Eating Disorder (Anorexia/Bulimia)		
Family Issues/Divorce		
Obsessive Compulsive Disorder		
Panic Attacks		
Substance Abuse/Chemical Dependency		
Suicidal ideation or attempts		
Other		

Is the applicant currently receiving treatment or counseling for a mental health condition?
_____Yes _____ No

If yes, please explain current cause, frequency and means of treatment. Attach additional sheet if necessary.
_____
_____
_____

If yes, please list and name and contact number of the applicant's therapist/counselor:
_____

4. **Allergies**. Please note any allergies to food, medicines, insects/bees, plants, latex, etc. Please note any systemic reactions:

_____
_____
_____

Has the applicant ever been stung by a bee? _____ Yes _____ No

If appropriate, the applicant should bring 2-3 Epi-Pens or Twinjects with them on the course.

Water may be disinfected with iodine. Is Iodine contraindicated for this person? _____Yes _____ No

5. **Dietary Restrictions/Preferences**. Please specify:

_____ None
_____ Gluten Free
_____ Peanut Free
_____ Nut Free
_____ Vegetarian
_____ Vegan
_____ Lactose Intolerant
_____Other:_____

6. **Cold/Heat/Altitude**. Please check box if applicant has or has a history of any of the following:

Condition	√	Comments.
Frostbite		
Raynaud's Syndrome		
Acute Mountain Sickness		
High Altitude Pulmonary/Cerebral Edema		
Heat Stroke		
Other Heat Related Illness		

7. **Prior Injuries within the last 3 years**. Please list or indicate NONE. Include broken bones, tears, significant sprains/strains, concussions/head injuries, etc. Attach additional sheet if needed.

Dates	Description of Injury

8. **Medications**. Please list or indicate NONE. Include vitamins, minerals and over-the-counter medication. Attach additional sheet if needed.

Medication	Taken For	Dosage	Date Started	Current Side Effects

Does this person plan to take prescription/non-prescription medication with them? _____ Yes _____ No

If yes, the participant must understand the use of any prescription medications they may be taking. Written and specific instructions are necessary. All participants 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. However, the instructors do need to know what the participant is taking for safety purposes.

_____I (The participant) understand and agree to this requirement

9. **Surgical Procedures** (Any surgical procedure, including knees and shoulders) Please list or indicate NONE.

Date	Procedure	Reason	Status/Prognosis

10. **Fitness**. Please provide details concerning the applicant's exercise regime.

Does the applicant smoke? _____ Yes _____ No

Is the applicant able to complete a mile in 10 minutes (Male) or 12 minutes (Female)?
_____ Yes _____ No If No, please list their time: _____

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

Swimming Ability (Check One) □ Non-Swimmer □ Recreational □ Competitive

11. **Foreign Travel**.

Dates	Countries Visited

12. **Immunizations/Vaccinations**. Date of last tetanus inoculation: _____

If your record of the applicant includes immunizations, please provide a copy with this form.

13. **Assessment**. Please check one of the following and provide necessary comments. This assessment is required in order for the student to be cleared to participate in the expedition.

_____Full participation with no concerns.

_____Participation with concerns being
_____

_____Participation ONLY if the following is addressed
_____

_____No participation due to
_____

How long have you known the applicant? _____

By my signature, I attest that the information in this form is complete and correct.

_____ _____
Physician Signature Date of Exam

_____ _____
Physician Printed Name Telephone Number

_____
Street Address

_____ _____ _____
City State Zip

The applicant must return this **physician-completed and signed** form by July 1, 2024 to:
Wyoming Catholic College, Attn: Registrar, 306 Main Street, Lander, WY 82520