Summer Ecology Health Evaluation Form

To be completed by a health professional (RN, CNP, PA MD or DO)

Field Ecology in the Rockies is an experiential learning opportunity involving high levels of activity including mountain biking, backpacking, canoeing, and other activities in an outdoor environment. Please assess the following health criteria accordingly.

Applicant's name Last: First:	Date of birth

If the answer to any of the questions below is "yes", the health care provider should provide details on the last page, indicating in each case whether the condition is likely to affect the student's full participation in the course.

	YES	NO	*IF "YES" please explain*
1. Currently under treatment or observation for any physical or emotional condition?	❑	❑	
2. Have any dietary restriction or food allergies?	❑	❑	
3. Allergic to any medications?	❑	❑	
4. Suffer from any other type of allergy?	❑	❑	
5. Have any speech, hearing, or vision impairment that might affect his/her participation?	❑	❑	
6. Have any physical disability that might cause hardship in the event of strenuous travel?	❑	❑	
7. Have any existing congenital condition that may require additional treatment?	❑	❑	
8. Have any communicable or infectious disease?	❑	❑	
9. Symptoms such as mood swings, depression, sleep disorders, unusual degree of anxiety, fear or guilt?	❑	❑	
10. To your knowledge, are there any predisposing medical or emotional factors that may, under stress or duress during the course of the study program, present a need for immediate therapy while abroad?	❑	❑	

Please list medications the applicant is presently taking, give the dosage and the generic equivalent. (please print)

Over...

We suggest the following tests and immunizations. Please indicate if and when the student has had them:	YES		NO
1. Tuberculin Skin Test Results_____	❑	Date Received:	❑
2. Dip./Tet.	❑	Date Received:	❑
3. Poliomyelitis	❑	Date Received:	❑
4. HEP A	❑	Date Received:	❑
5. HEP B	❑	Date Received:	❑
Other medication and final comments:			

PROVIDER INFORMATION	
Health Care Provider Name (please print):	
Address:	Date:
Email:	Phone:
Signature:	

On Completion:

Before June 21, 2017, please either scan this form and email to Dr. Grant Hokit (ghokit@carroll.edu) or mail the original to:

Dr. Grant Hokit
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Helena, MT 59625