



AMERICAN  
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# High Adventure Activity Medical Form

This form is valid for 12 months.

This form should be kept at the Troop level.

Please attach to the AHG Health and Medical History Form.

Participant Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Health Examination:** To be completed by a Licensed Health-Care Provider

**The applicant will be participating in a strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge, or wilderness expedition (afloat or afloat) that may include high altitude, extreme weather conditions, cold water, exposure, fatigue, and/or remote condition where readily available medical care cannot be assured.**

Date of Exam: _____ Height _____ Weight _____ B.P. ____/____ Pulse _____	<b>Vision:</b> Normal _____ Glasses _____ Contacts _____	<b>Hearing:</b> Normal: _____ Abnormal: _____
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Check box if normal; circle if abnormal and give details below:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Growth, development | <input type="checkbox"/> Teeth, tonsils   | <input type="checkbox"/> Genitourinary       | <input type="checkbox"/> Skin, glands, hair     |
| <input type="checkbox"/> Respiratory         | <input type="checkbox"/> Skeletomuscular  | <input type="checkbox"/> Head, neck, thyroid |   |
| <input type="checkbox"/> Cardiovascular      | <input type="checkbox"/> Neuropsychiatric | <input type="checkbox"/> Eyes, ears, nose    | <input type="checkbox"/> Abdomen, hernia, rings |
| <input type="checkbox"/> Other (specify)     |   |  |   |

**Comments/Details:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Dietary Restrictions

\_\_\_\_\_

Approved for participation in:

\_\_\_ Hiking      \_\_\_ Water Activities      \_\_\_ Competitive Sports      \_\_\_ All activities

Specify exceptions:

\_\_\_\_\_  
 \_\_\_\_\_

Recommendations (explain any restrictions OR limitations)

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Is medication information on the Health and Medical History Form up to date and current? YES NO  
If no, please provide updated information. Attach a separate sheet if needed.

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Signature of Licensed Health Care Practitioner (AHG, Inc. allows **MD, DO, PA, CNP** to sign)

\_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

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