Sky Ranch Physician's Medical Examination

A medical examination is REQUIRED for any participant attending any part of their camp session in Colorado

Participant's Name: _____ DOB: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

To Physician: Sky Ranch is a camping experience that is one or more weeks in duration. Participants may engage in strenuous activities during their stay. These can include, but are not limited to rock climbing, rappelling, ropes course, white water rafting, hiking backpacking, and kayaking. Sky Ranch camps in Colorado are in excess of 8,300 feet in elevation. We rely on your evaluation to determine if this person is physically capable of attending this camp.

PHYSICAL EXAM	WNL	Abnormal
HEENT		
Heart		
Lungs		
Abdomen/Pelvis		

PHYSICAL EXAM	WNL	Abnormal
Skin		
Neck/Back		
Upper Extremities		
Lower Extremities		

Please describe abnormal findings:

HISTORY OF:	Yes	No		Yes	No
Hearing Disorder			Orthopedic Injury or Disorder		
Visual Disorder			Heart Murmur/ Irregular heartbeat		
Heart Disease			Dizziness with Exercise		
Stroke			Headaches		
High Blood Pressure			Weight Loss/Anorexia/Bulimia		
Diabetes			Enuresis		
Seizures			Been hospitalized in the last year		
Asthma/Shortness of breath			Psychological conditions		
Allergies to medicine			Allergies to food		

Other medical conditions:

If yes to any of the above, please explain: _____

☐ Yes ☐ No Restriction on activities? By whom? _____

List activities that are restricted: _____

Please list any prescription or over the counter medications the participant will be taking daily during camp. Include all vitamins, supplements, and non-FDA approved medications. (Please list additional medications on a seperate sheet if needed):

MEDICATION NAME	DOSE/STRENGTH	REASON/CONDITION	WHEN TO ADMINISTER

This Required Physical Examination form or other Physical Exam form must be filled in and signed by either a Physician, a Physician Assistant licensed by the State Board of Physician Assistant Examiners, or a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners. Examination forms signed by any other health care practitioner, including chiropractors, will not be accepted.

In my opinion, the health of the named participant does not preclude his/her participation in the activities at Sky Ranch camps.

Physician's Printed Name:_____ Signature:_____ Date:_____

If signature date differs from date of examination, please specify: _____