

**TOUCH OF NATURE ENVIRONMENTAL CENTER - SOUTHERN ILLINOIS UNIVERSITY AT CARBONDALE
MEDICAL EXAMINATION**

SPECTRUM WILDERNESS PROGRAM

MEDICAL EXAMINATION is to be performed by a licensed physician. This examination should be performed within twelve months of arrival/participation at Southern Illinois University, Carbondale. A comparable examination for some other purpose is acceptable. Examination is for determining fitness to engage in outdoor education/recreation program(s).

PLEASE PRINT OR TYPE ALL INFORMATION

Student's Name: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Respiration: _____
 Temperature _____ Hemoglobin: _____ Glasses/Contacts: [] yes [] no Hearing Aids L _____ R _____

General Health and Nutrition:

Skin: _____	Abdomen: _____	Ears: _____
Lymph: _____	Extremities: _____	Thyroid: _____
Eyes: _____	Feet: _____	Hernia: _____
Mouth & Throat: _____	Knee: _____	Scars: _____
Neck: _____	Urinalysis: _____	Ankles: _____
Thorax & Lungs: _____	Hemoglobin: _____	Posture (spine): _____
Heart: _____	Glasses: _____	Peripheral Vision: _____
	Teeth: _____	Genitalia: _____

Allergy (please specify): _____

The applicant is under the care of a physician for the following condition(s): _____

Current treatment(s): _____

Does the applicant experience seizures? [] yes [] no. Is applicant diabetic? [] yes [] no.

Explain: _____

If applicant is female: Has person menstruated? [] yes [] no. If yes, is her history normal? [] yes [] no.

If not, is she aware of menstruation? [] yes [] no. Special considerations: _____

RECOMMENDATIONS AND RESTRICTIONS

Medications to be administered while participating (please print)

NAME	DOSAGE/TIME

Any treatments to be continued while participating: _____

Any medically prescribed meal plan or dietary restrictions: _____

On the basis of your past knowledge, the applicant's medical history and the present physical examination of this applicant, do you see any reason why this individual should not participate in an outdoor education/recreation program? _____

SIGNATURE OF EXAMINING PHYSICIAN: _____

ADDRESS: _____

TELEPHONE (_____) _____ FAX (_____) _____

DATE: _____ BY: _____