

Medical Form

Check one. WOW 1 '09 _____ WOW 2 '09 _____

Personal Information

Name _____
LAST FIRST

Home Phone () _____ Work Phone () _____

Email _____ Male _____ Female _____ Age _____

Description of the Courses

PHYSICIAN AND PARTICIPANT PLEASE READ

The Way of a Warrior courses are rigorous, involving long hours, some strenuous activity and the potential for emotional stress. The strenuous activity includes daily physical exercise, daily running of up to two miles, games including several minutes of sport running and the possibility of two or more hours of dancing. Each participant is encouraged to participate fully while honoring individual physical limitations put forth by their physician. The WOW II course will add white water rafting and a challenge/ropes course to the list of physical activities. These activities do not require a participant to be in prime physical condition, but they can be quite taxing.

In Section H, the physician approves, approves with conditions or disapproves of the full participation in these activities.

Medical Examination Information

This medical examination is to determine fitness to engage in strenuous activities as outlined above.

If you are being treated, or have been treated, for a chronic medical condition, your physician, who is familiar with this condition, must be informed about the activities of this course and must approve of your participation. (Some examples are back pains or other orthopedic problems and diabetes, thyroid disorders or other endocrine problems.) Please: FILL OUT THE FORM COMPLETELY AND ACCURATELY. EVERY LINE MUST BE FILLED IN. Answer each question: write N/A if not applicable. Return this form to dreena.tischler@moretolife.org or fax to 512-287-5399 or mail to Dreena Tischler, 2307 Berwick Drive, Round Rock Texas 78681 USA by May 20.

Section A Medical History

Completed by the participant and checked by the physician.

PHYSICIAN'S NOTE:

Indicate medical history and detail below. Attach separate sheets if necessary. Include dates of most recent occurrence, current medical treatment and medicine prescribed, and whether this condition will interfere with full participation in this 6-day course.

Do you have or have you ever had the following?

Neurological Problems	Lung Disease	Diabetes Mellitus	Hernia
Epilepsy	Asthma	Hypoglycemia	Major Surgery
Heart Disease	Allergies	Thyroid/Endocrine	HIV Positive/Hepatitis B
Hypertension	Kidney Disease	Orthopedic Problems	Psychiatric Problems

Women Only	YES	NO		YES	NO		
Gynecological Problems			Are you pregnant?			Due Date	/ /

Details

Section B
Laboratory
Exam

To be completed by the physician. Physician should determine the necessity of the hemoglobin test for the patient.

Height _____ Weight (lbs/kg) _____ Blood Pressure _____ Hemoglobin _____

Section C
Physical Exam

Examination of structure and function. Please check NORMAL (N) or ABNORMAL (A).

	N	A		N	A		N	A
Eyes			Teeth			Back		
Ears			Heart			Posture		
Nose			Lungs			Extremities		
Throat			Abdomen			Skin		

Corrective Lens? Yes _____ No _____

Explain any items marked abnormal (A).

Section D
Tetanus
Immunization

We strongly recommend you have a current tetanus immunization.

Date of last tetanus _____

Section E
Resting ECG

Required for those with a history of heart disease or arrhythmia. Recommended for others but not mandatory.

Normal _____ Abnormal _____

Section F
Required
Medication

Does the participant require medication? Yes _____ No _____

If yes, participant must bring required medication. Please give details of medication, including over the counter and herbal remedies, you are currently taking or have taken in the last month.

Current Use	Used in Last Month	Name of Medication	Dosage	Instructions

Section G
Diet

Does the participant require a prescribed or special diet? Yes _____ No _____

If special foods are required please consult with Coordinator on what arrangements will need to be made. Please list dietary requirements, i.e. high protein, allergies, vegetarian, vegan.

**Section H
Physician's
Approval**

If this form is completed by a nurse practitioner or physician's assistant working under an M.D., D.O., or D.C., the physician must sign this form.

The WOW courses require participation in all activities. To be approved, each person must be able to participate fully in each part of this course.

The following approval must be signed by your examining physician.

_____ **Yes, I approve my patient's participation.**

_____ **Yes, I approve my patient's participation with the following conditions listed under "Additional Comments" below.**

_____ **No, I do not approve my patient's participation.
(If "no," list reasons why in space provided below.)**

Physician's Signature _____ Date _____

Additional Comments:

**Section J
Physician's
Information**

Type or print the following information:

Examining Physician _____ M.D./D.O./D.C.

Street Address/P.O. Box _____

City _____ State _____ Zip _____ Country _____

Phone Number _____

**Section K
Participant's
Responsibility**

The participant is responsible for having this form completed with accuracy and absolute integrity.

I have read and understand the information contained in this form and know that the information is accurate and complete. I am able to and will participate fully in the course. I agree to follow the instructions of my physician pertaining to medications.

Signature _____ Date _____
