Medical Physical part of the Will's Hope Application – Due no later than 28 Feb 2024
The medical physical must be on this form.
Will's Hope Medical Information & Physical needed for 2024 Participants

Note: If there are any questions related to the medical requirements, please contact Mark Squire 719-210-5625

Dear Participant:

There are several medical items/tasks that must be completed in order to complete the medical preparation for Will's Hope. **Pages 2 to 5** must be returned to Will's Hope. **Please use this form for page 3 to 5. Other forms (medication list can be on another form as long as the information we need is included) are not acceptable. Your physical should be on Page 3 to 5.**

Please submit this form in hard copy.

These are:

1. **Medication List** with name, dosage, frequency & purpose – Please use table format similar to that on the next page (**page 2**). **If you use another form for the medication list please be sure that the information listed on page 2 of this document is included, as a minimum, on the form you are using. It is very important that all medications – prescribed & over the counter are listed.** If there are changes to the list after submission to Will's Hope, please ensure we are kept informed. Each participant is responsible for bringing their medications and taking them as required. The program nurse/medic/medical professional will have a copy of these medical documents. **The participant's on-hand medications must match this list**. The list will be provided to emergency medical personnel and or medical clinics/hospitals if the participant needs higher level treatment.

2. A **Physical** performed by a licensed physician, nurse practitioner or physician assistant. Please use **page 3 - 5** of this document for the physical. **Physicals must occur after 1 Jan 2024** and be specific to Will's Hope & the Greater Yellowstone Ecosystem Region environment which includes Yellowstone National Park. **Please use this form as other forms are not acceptable.**

3. Optional - Each participant provides a copy of any medical insurance card(s)- both sides, and if applicable related insurance authorization documents. At a minimum, each participant must bring their IDs, and any medical insurance cards that would be required by a clinic or hospital.

Suspense Dates:

1. **Please return pages 2 to 5 by 28 February 2024 along with your application.**

Medication List

Will's Hope Participant's Name _____

Please complete the table below and take it with you when your physical is performed. The examining physician, nurse practitioner or physician assistant should review this list. If needed please bring a rescue inhaler (for asthma) and for severe allergies at least two doses of a prescription epinephrine injection device (Epi-pen) but confirm this with your medical provider. If applicable, include the inhaler and Epi-Pen on the list below. Medication Purpose = what is the reason for the medication. **If you use another form for the medication list, please be sure that the information listed below is included, as a minimum, on the form you are using.**

Participant's Name _____ Please **print legibly**

Medication	Dosage	Frequency	Medication Purpose	Comments
Example				
Xyz	500 mg	2 x daily		

Information to be filled in by the participant (# 1 & #2 below) & your name at the top of each page:

Will's Hope Participant Name: _____

Medical - Physical for individuals participating in Will's Hope 2024 – Due no later than 28 Feb 2024

To the examining Health Care Professional (Licensed physicians, nurse practitioners and physician assistants): Please verify the individual listed below is physically able to participate in Will's Hope.

Description of Program: Will's Hope is a 9+ **day outdoor educational immersion program**. The location of the program is in the **Greater Yellowstone Ecosystem (GYE)**. In the **May & June** timeframes temperatures can range from below freezing to 90 deg F. The Program occurs at **5,000 feet to 10,000 feet in elevation**. It is possible to have short sleeve weather in one part of the GYE while blizzard like conditions occur in another part of the GYE. **Program participants** should be able to comfortably hike **3 miles with elevation gains of 600 feet** on a daily basis. Lodging for participants is in developed facilities with all utilities and customary items. The overall environment is semi-arid. Hiking & training in the Colorado Springs area will occur prior to the program. The programs in 2024 are:

- 26 May to 3 June 2024 (Women's Program)
- 7 June to 15 June 2024 (Men's Program)

All participants must hydrate starting at least 7 days prior to the start of Will's Hope to minimize the chances of dehydration during the Program. Participants are encouraged to start an active hiking program and increasing hydration no later than early March 2024.

Pandemic related precautions – all participants and immediate friends/families are advised to take appropriate precautions prior to program activities in order to minimize the chances that participants may be sick & affect other members of the group. We encourage everyone to be vaccinated. If necessary, Will's Hope will utilize masks and enforce social distancing. As required, vans, lodging, equipment, touch surfaces, etc. will be disinfected. Will's Hope will follow the guidance of the CDC, public health agencies, US Forest Service and the National Park Service (NPS).

Please fill in the blanks so answers are legible.

1. **Participant's full Name:** (Please print legibly) _____

   Date of birth _____ Age: _____

2. **Medical emergencies** while participating in Will's Hope. In case of a medical emergency, while participating in Will's Hope (in the event the local healthcare professional/practice needs to be consulted with), please provide the contact information for the appropriate medical provider in the Colorado Springs area or in your home location for discussions with the medical staff in the Greater Yellowstone Ecosystem (GYE) Region (Note: **This may be someone (or a medical practice/hospital) other than the examining Health Care Professional)**. This should be a 24/7 telephone number.

   Emergency Medical Practitioner/Facility Name (Please Print Legibly): _____

   24/7 Telephone Number: _____

Participant's Name _____

Information to be filled in by the Health Care Professional that performs the physical exam (#3 through #5 below):

3. Basic Information

Date of exam: _____ **Please be legible, Thank you!!!**

Height (inches): _____ Weight (pounds): _____

Blood Pressure _____/_____ Pulse: _____

4. Physical Exam

Please √ the appropriate column (Normal, Abnormal or Not Applicable (N/A)) & provide any relevant comments.

	Normal	Abnormal	N/A	Comments
Eyes				
Ears				
Nose				
Throat				
Lungs				
Heart				
Abdomen				
Genitalia/Hernia				
Skin				
Knees				
Ankles				
Spine				
Other musculoskeletal				
Neurological				
Other				

What are participant allergies, if any _____
(Please consider all possible allergies – food, medications, bee stings, etc.)

Please √ the appropriate column (Yes, No or Not Applicable (N/A)) and provide any relevant comments.

	Yes	No	N/A	Comments
If the individual has serious allergies is an epinephrine injection device (Epi-pen) required?				
If the individual has diabetes, is it managed adequately and under control?				
If individual has diabetes is the participant able to manage its treatment without assistance?				
If participant has had asthma are there any actions required during Will's Hope?				
If the participant has asthma is a rescue inhaler necessary and does the participant have the correct type?				
Seizure concerns?				
Hydration concerns?				
Eating disorder (e.g., purging after meals) concerns?				
Are immunizations to include tetanus current?				
List of medications reviewed?				
Family medical history is unremarkable?				
Individual medical history is unremarkable?				
Other				
Other				

Participant's Name _____

5. Health Care Professional's Assessment:

a. Are there areas of concern that are not listed above that Will's Hope staff should be aware of? □ **Yes** □ **No**

If yes, please explain_____

b. Please provide any other comments or observations _____

_____

_____

c. **Participant is cleared for participation in Will's Hope** □ **Yes** □ **No**

If no, what conditions must be met to allow participation? _____

If participant is able to meet the conditions is a re-exam by medical personnel required? □ **Yes** □ **No** □ **N/A**

Please explain if necessary _____

To be signed by the Health Care Professional Who Performs the Exam – **Please be legible**

Printed Name: _____ **Title:** (Dr. NP, PA) _____

Address: _____

City, State & Zip Code: _____

Office Phone: _____

Examining Health Care Professional Signature _____ Date: _____

Thank you very much for helping Will's Hope and the Participant!