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# Extended Travel Youth Health Forms

To be completed and signed by the parent/guardian of youth.
Section 1 – Extended Travel (3+ Days) Health History
Section 2 – Extended Travel (3+ Days) Physician Exam

| **Youth Full Name:** | | **Date of Birth:** | **Age:** |
|---|---|---|---|
| **Address:** | | | |
| **Parent/Guardian Name:** | **Phone:** | **Email:** | |
| **Physician's Name:** | | **Phone:** | |
| **Emergency Contact:** | **Phone:** | | **Relationship:** |

## Section 1 Extended Travel (3+ Day) Health Form – to be completed by parent/guardian

| **Secondary Emergency Contact** | | | |
|---|---|---|---|
| **Name** | | **Phone** | |
| **Relationship** | | **Secondary Phone** | |
| **Email** | | | |

| **Additional Medical History -** Check all that youth has had | | | |
|---|---|---|---|
| | Chicken Pox | | Mumps |
| | German Measles | | Rheumatic Fever |
| | Kidney Disease | | Tuberculosis |
| | Measles | | Other: |
| Please explain in detail any items checked above: | | | |
| Has your youth had any adverse reactions to general anesthetics? Yes/No | | | |
| Any other information not covered in this form that is important that advisors for this trip should know about? Use the additional sheet if necessary. | | | |

CONTINUE SECTION ONE ON THE NEXT PAGE

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| **Medical Conditions and/or Concerns**<br>Please include any precautions or restrictions on activities, as well as concerns relating to emotional and mental well-being (including self-harm, depression, effects of medication on their behavior, eating disorders, etc.). We want to provide the most supportive environment possible, and a large part of that is knowing what's going on with trip participants. The more information you provide, the better we can work with you to establish a plan. | |
|---|---|
| Name of Condition | Effects |
| | |
| | |
| | |
| Additional Information or Comments: | |
| Has your youth had any adverse reactions to general anesthetics? Yes/No | |
| | |

END OF SECTION ONE

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**Youth Name**___________________________

# Section 2 – Extended Travel (3+Day) Health Examination Form – to be completed by Physician

| **Trip Information -** Must be completed by Parent/Guardian | |
|---|---|
| Trip/Activity: | |
| Region/Location: | Date Range of Trip/Activity: |
| Distance from Emergency Medical Services: | Level of First Aid Required: |
| Trip/Activity Description: Include a brief description of your trip. This will help the medical professional evaluate your physical readiness for the trip. Please note if different activities will be done (ex. rock climbing, cultural sites, etc.) | |
| | |

**Record of Immunization -** Complete in detail and attach documentation

| Immunization | Date Series Completed | Year of Last Booster | Immunization | Date Series Completed | Year of Last Booster |
|---|---|---|---|---|---|
| Hepatitis B | | | Hepatitis A | | |
| Diphtheria, Tetanus, Pertussis (DTap/Tdap) | | | Inactivated Poliovirus (IPV) | | |
| Measles, Mumps, Rubella MMR) | | | Influenza | | |
| Rotavirus (RV) | | | Varicella | | |
| Haemophilus influenzae type b (Hib) | | | Meningococcal (MCV) | | |
| Pneumococcal (PCV) | | | Human Papillomavirus (HPV) | | |
| IPV/OPV | | | Typhoid | | |
| Paratyphoid | | | Cholera | | |
| Yellow Fever | | | Typhus | | |
| Rocky Mountain | | | Spotted Fever | | |
| Rota | | | Covid-19 | | |
| Tuberculin Test: Year last given:________________ Results:___________________ | | | | | |

CONTINUE SECTION TWO ON THE NEXT PAGE

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| **Medical Examination Form -** Must be completed by a licensed physician, nurse practitioner, physician assistant or registered nurse within the preceding 12-24 months, unless a health issue is present. | | | | | | | |
|---|---|---|---|---|---|---|---|
| Height: | | Weights: | | Blood pressure: ______/________ | | Pulse Rate: | |
| Hearing: R_________ L________ | | | Eyes: With Glasses R 20/_____ L20/_____ | | Without Glasses R 20/_____ L20/_____ | | |
| **Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined** | | | | | | | |
| | Nose | | Lungs | | Urinalysis | | Musculoskeletal |
| | Throat | | Abdomen | | HGB | | General Physical State |
| | Teeth | | Hernia | | Skin | | General Emotional State |
| | Heart | | Genitalia | | Appearance/Nutrition | | Other |

Licensed Physician Name:_________________________________ State License Number:_________________________
Phone Number:________________
Address:_______________________ City:________________ St:________________ Zip:________________

This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities except as noted. Yes/No

Signature of Licensed Physician:________________________________Date: _______