



STUDENT NAME: \_\_\_\_\_ What HMI Program are you attending? \_\_\_\_\_

Today's Date: \_\_\_\_\_ Student's Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Mother's Day Phone: ( ) \_\_\_\_\_ Father's Day Phone: ( ) \_\_\_\_\_

Mother's Evening Phone: ( ) \_\_\_\_\_ Father's Evening Phone: ( ) \_\_\_\_\_

The student or student and his/her parent (or guardian) should complete pages 1-3 with assistance from the medical care provider as needed. The examining medical care provider must complete page 4 after reviewing (and assisting, as needed, with completion of) pages 1-3.

We ask that you complete this form carefully and accurately. This information will be shared only with HMI personnel, consulting and treating medical personnel and other individuals working with HMI. Otherwise, the information will remain confidential.

### Program Information for Medical Professionals, Students, and Parents

Participation in HMI activities includes a review of a student's medical and health information. Disclosing information in this form does not automatically exclude participation. HMI would like to obtain accurate information about student's health, and understand any medical or health concerns or limitations. HMI activities can be strenuous and can offer exercise different from what the student may be accustomed to.

Students on our programs may be exposed to some or all of the following activities & challenges:

- Rigorous physical challenges
- Rigorous mental challenges
- Intellectual or academic challenges
- Activities requiring intense focus and careful attention for extended durations
- High Altitudes (campus is at 10,000 ft. above sea level, expeditions often go to 14,000 feet)
- Travel in remote mountain and desert areas up to days from modern medical facilities
- Carrying heavy backpacks (35-45% of his/her body weight)
- Difficult, uneven terrain on foot or skis
- Cooking meals in a commercial style kitchen and on one-burner stoves in the backcountry
- Sleeping in rustic cabins, tarps, tents and snow shelters
- Manual labor such as shoveling snow, splitting firewood, trail work
- Exposure to extreme temperatures (-30°F to +100°F)
- Immersion in cold water
- Regular exposure to intense sunlight and extremely dry air
- Exposure to severe wind, rain and snow storms

HMI programs are for motivated, energetic, and fundamentally healthy students.

HMI does not provide programs for students to resolve or work on behavioral, emotional, or psychological problems.

HMI cannot provide appropriate support for students attempting to quit tobacco use, drug use, or alcohol use or to recover from prior substance abuse problems.

**If the student is on any medication**, please be specific about possible side effects, potential effect of a missed dosage, and how high altitudes and/or strenuous physical activity may affect the student taking the medication.

*Students and their parent/s can review the HMI Acknowledgment and Assumption of Risks for additional details about these activities and the associated risks. Please contact us if the student, parent/s, or medical care provider has any questions about the student's ability to participate or other concerns.*



Hx: Does the student have any past, present or current problems with any of the items listed below? If "YES" to any of these conditions, please explain in detail below and attach additional sheets as necessary.

Table with 9 columns: CONDITION / PROBLEM / ILLNESS, YES, NO, N/A, and a second set of the same columns. Rows list various medical conditions such as Acute Mountain Sickness, Allergies, Asthma, Attention Deficit Disorder, etc.

For any "YES" answer above please describe the condition or problem completely, including treatment, dates, and medications given (attach additional sheets as necessary):

Multiple horizontal lines provided for writing a detailed description of any 'YES' answers.



Other Medical Care: Does the patient see a specialist or other health care provider of any kind?  Yes  No

If yes, why? When? What type of specialist? Please list name, address, and telephone: \_\_\_\_\_

Psychological: Has the student ever been treated by a counselor or a mental health professional?  Yes  No

If yes, why? When? Please list name, address, and telephone of therapist or counselor: \_\_\_\_\_

Is the student currently receiving treatment or counseling with a mental health professional?  Yes  No

If yes, why? Please list name, address, and telephone of therapist or counselor: \_\_\_\_\_

Allergies: List all allergies to medications: \_\_\_\_\_

List all food or other allergies: \_\_\_\_\_

Does the student have any severe allergic reactions to insect stings/bites or foods?  Yes  No

If yes, does the student have a current prescription for a bee sting or epinephrine kit/pen?  Yes  No

Medications: Is the student currently taking any medications?  Yes  No (Attach additional pages as necessary)

Medication	Dosage	Side effects/restrictions	Prescribed by	For what condition	Start Date

Current Physical Conditioning: Does the student get regular exercise?  Yes  No Please describe: \_\_\_\_\_

General Readiness: Does the student have any condition (e.g., mental, physical, emotional), either identified above or otherwise, which might affect his/her health or well being, the well being of others, or affect his/her ability to engage in HMI activities? If so, please describe. Attach additional pages as needed. \_\_\_\_\_

Limitations: Are there any limitations on the student's ability to participate in any HMI activities? If so, please describe (including any adaptations or modifications appropriate or necessary). \_\_\_\_\_

Does the student use tobacco products?  Yes  No If yes, how much? \_\_\_\_\_

Is the student under or over weight?  Yes  No If yes, by how much? \_\_\_\_\_

To the best of my knowledge, this medical form contains accurate information. I will contact HMI if any medical or health condition changes before the start of the HMI program. I understand that providing inaccurate medical or health information or falsifying medical or health information can create serious risks to the participant or others, and/or can result in participant's dismissal from the program. I understand the participant's ability to participate is contingent upon HMI's representatives' review of all forms, including this one. I understand that although HMI will review this information and may allow participation, HMI cannot anticipate or eliminate risks or complications posed by an individual's mental, physical, or emotional condition

_____ Student/Participant Signature	_____ Date	_____ Print Full Name Here
_____ Parent or Guardian Signature	_____ Date	_____ Print Full Name Here
_____ 2 <sup>nd</sup> Parent or Guardian Signature	_____ Date	_____ Print Full Name Here



***The remainder of this form is to be filled out by the student's primary care provider.***

***Medical Care Provider:*** Please read the program description on page 1, review pages 2 and 3 carefully and assist in completing the information found therein, and then complete this page.

**Required Health Care Recommendations by Licensed Medical Personnel:** I have reviewed the information in this form regarding program location, activities, and risks, and have assisted the student and parent/s, as necessary, in completing this form in conjunction with my examination.

I examined this individual on \_\_\_\_\_(date), Pulse:\_\_\_\_\_ BP:\_\_\_\_\_ Height:\_\_\_\_\_ Weight:\_\_\_\_\_ BMI:\_\_\_\_\_

Date Tetanus Inoculation? \_\_\_\_\_(Students need a Tetanus Inoculation w/in last 10 years. If outdated, then please administer today if possible)

The student is under the care of a physician for the following conditions: \_\_\_\_\_

\_\_\_\_\_

Recommendations and Restrictions on the HMI program: \_\_\_\_\_

\_\_\_\_\_

Treatment and medications to be continued at HMI (please refer to previous pages of this form for any medications, known allergies or dietary restrictions, or limitations (including appropriate modifications) and/or restrictions on HMI program activities): \_\_\_\_\_

\_\_\_\_\_

Additional health care considerations for HMI: \_\_\_\_\_

\_\_\_\_\_

I have examined the student named on this form and understand he/she is planning to attend HMI. I have reviewed all health and medical information supplied in this form for its accuracy. I understand the nature of the activities, as set forth above, and acknowledge that HMI representatives are available should I have further questions about the nature and/or physical or emotional demands of these activities. I understand that the student will be traveling in remote areas where medical care may be significantly delayed. Considering any restrictions stated above, the student can, in my opinion, fully participate in the HMI program. I am not related to the student.

Signature of Medical Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Clinic/Hospital Name & Address: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

***Thank you for your time and effort in filling out this form. If you have any questions or comments please do not hesitate to contact us at: (719) 486-8200 or via e-mail at [hmi@hminet.org](mailto:hmi@hminet.org).***