Wild Dharma Medical Application

This Medical Application is submitted in connection with, and is incorporated into, the BZC Wild Dharma Acknowledgment of Risks and Agreement of Release. We may require follow-up questions from you and/or your physician. All information will remain confidential, except as required by law or as necessary to ensure participant safety. The Wild Dharma program, while designed with safety in mind, is a serious experience with real risk and hazards heightened by remote settings, altitude, and other environmental hazards where medical attention may not be readily available. It is important for the success of our expeditions and for your and others' safety that BZC Wild Dharma has accurate information regarding your current health and medical history to make judicious decisions. Your health, safety and comfort are our highest priority. Please accurately fill out every page of the application.

To accept this application, all pages must be completed as follows:

- ❑ Every line must be filled out
- ❑ Every "yes" or "no" box must be checked
- ❑ Provide additional information for every "yes" box checked
- ❑ For participants under 18 years of age, a parent or legal guardian must sign below on the participant's behalf and agrees to all terms herein. A minor's signature alone is not legally sufficient.

General Information

Your Name_____ Date_____/_____/_____

Address_____ City _____ State_____

Zip_____ Phone(c) _____ Phone(h)_____

Email_____ Date of Birth_____ Age_____ □ M □ F

Primary Emergency Contact:

Name_____Relationship_____Phone(h)_____

Phone(w)_____ Phone(c)_____Email_____

Secondary Emergency Contact:

Name_____Relationship_____Phone(h)_____

Phone(w)_____ Phone(c) _____Email_____

Do you have insurance? □yes □ no

Insurance Company_____ Phone#_____

Policy/Certificate #_____

Do you have a physician? □yes □ no

Name_____Phone_____

Approval (office use)

Additional Medical Follow-up	□N/A □COMPLETE	blood pressure ____/___
Final Approval	□COMPLETE	date and initials _____
Copy Made/Given to Guide	□COMPLETE	date and initials _____

Expedition and Date: _____

Conditions and Symptoms

Your Name_____

Do you currently have or have in the past had any of these conditions?

#	Condition	Y	N	#	Condition	Y	N	#	Condition	Y	N
1	Vision impairment (including contacts and glasses)			22	Frequent dizziness or fainting			44	Currently pregnant		
2	Hearing impairment			23	Seizure disorder/epilepsy			45	Shoulder problem		
3	Motion sickness			24	Seizure w/in past year			46	Knee problem		
4	Headaches/migraines			25	Diabetes			47	Elbow problem		
5	Circulation problems			26	Hypoglycemia			48	Wrist/hand problem		
6	High blood pressure, over 150/90, even if controlled by meds			27	Cancer			49	Back problem		
7	Heart disease			28	Skin problems			50	Neck problem		
8	Heart murmur			29	Frostbite			51	Broken bones		
9	Irregular heart beat			30	Stomach ulcers			52	Ankle problem		
10	Family history of heart attack			31	Intestinal problems			53	Leg/Hip problem		
11	Unexplained chest pain/pressure			32	Bladder infection			54	Foot problem		
12	Heart palpitations			33	Difficulty urinating			56	Frequent muscle cramps		
13	Frequent heartburn			34	Kidney problems			57	Head injury/Neurological impairment		
14	Blood disorder (anemia/sickle cell trait)			36	Thyroid problems			58	Medical equipment/devices (prosthetics, pace makers, etc.)		
16	Bleeding disorder			37	Endocrine problems			59	Learning disability		
17	High Cholesterol			38	Heat stroke			60	Special diet		
18	Chronic cough			39	Altitude problems			61	Do you smoke?		
19	Asthma			41	Intolerance to cold temperatures			62	Hepatitis		
20	Recurrent lung infections			42	Intolerance to warm/hot temperatures			63	Tuberculosis (TB)		
21	Frequent shortness of breath			43	PMS/menstrual problems			64	Other		

*Tetanus immunization is recommended within the last 10 yrs.

If you answered yes to any of the above, please explain below

Item #	Detailed description

General Health

Your Name_____

Weight_____ Height_____

Do you have any allergies? ☐ yes ☐ no

Include any medicine, food, plants, insects, etc.…

Allergies	Reaction	Medication (if any)

Do you have any dietary restrictions? ☐ yes ☐ no

Include any medicine, food, plants, insects, etc.…

Food	Details important for the Chef

Do you currently take any medications? ☐ yes ☐ no

Include all medications you are taking (including those not prescribed by a doctor & inhalers)

Medications	Why taken(condition/symptom)	Dosage(how much/often)	Start date	Side effects(if any)

Have you had Hospitalization, Emergency or Urgent Care visits in the past 2 years? ☐yes ☐no

List any hospital, emergency department, or urgent care visits

Date of visit/admittance	Reason	Length of stay

Do you exercise regularly? ☐ yes ☐ no

Activity	Frequency	How long?

Counseling & Mental Health Your Name_____

Are you in counseling now or have been within the last 2 years? □ yes □ no

If yes, explain_____

_____

Have you experienced, been diagnosed, or seen counseling for any of the following? A "yes" answer does not automatically disqualify participation; all information is reviewed individually and kept strictly confidential.

□ Suicide □ Eating disorder □Violent behavior □ Bipolar disorder □other
□ Anxiety □ Major depression □ Schizophrenia □ Substance abuse

If yes, explain_____

_____

Have you ever been convicted of a felony? This information is requested solely for participant safety purposes and is not used for employment decisions. □ yes □ no

If yes, explain_____

_____

Signature for medical treatment

In consideration of this application to the Boulder Zen Center, I agree to the following conditions:

- I authorize BZC staff to seek and consent to emergency medical treatment on my behalf when I am unable to do so due to incapacity, consistent with my known medical history disclosed in this form. Where time and circumstances allow, I retain the right to provide specific informed consent as required by Colorado law (C.R.S. § 25-1-901 et seq.).
- All of the information given regarding my physical and psychological health is up to date and correct.
- If there are any changes to my health, I will notify the Boulder Zen Center and seek professional advice if asked to do so by the Boulder Zen Center.
- To take responsibility for my ability to participate in the physical demands of the BZC Wild Dharma experience.

Signature_____ Date_____ Printed Name_____ Date of Birth_____

(Participant) By signing above, I also authorize disclosure of the health information contained in this form to emergency medical providers and BZC program staff as necessary for my safety and care, pursuant to HIPAA, 45 C.F.R. § 164.508. If participant is under 18, parent or legal guardian must sign below:

Parent/Guardian Signature_____ Date_____ Printed Name_____ Relationship to Participant_____

Why do you want to be part of this program?

Have you been on an overnight backpacking/camping trip? □yes □ no
Please describe.

What are you nervous or unsure about?