



PO BOX 12 • 16 EAST 300 SOUTH • MONTICELLO, UTAH 84535

PHONE: (435) 587-2801 • FAX: (435) 587-3164

EMAIL: FAMILY@WILDERNESSQUEST.COM • WWW.WILDERNESSQUEST.COM

PHYSICAL FORM

PHYSICIAN OR HEALTH CARE PROFESSIONAL CONTACT INFORMATION		
Physician/Practitioner Name	Telephone	Fax #
Address	City	State/Zip

Dear Physician or Health Care Professional,

The above employee has accepted an offer to participate as a field staff member in an outdoor experiential and emotional growth program that is both physically and mentally challenging. Our agendas require that field staff hike between 3-10 miles daily and as many as 20 miles on occasion. Additionally---as may be expected when working for an outdoor program---field staff are exposed to sun, heat, cold, or other extreme weather conditions for prolonged periods of time. Hiking and other activities are performed at elevations between 4,000-7,000 feet in the winter and 6,500-11,000 feet in the summer, and field staff are also required to carry a bedroll and pack averaging 30 lbs. (but weighing up to 40 lbs.).

Under these conditions, a minimum of 2.5 gallons of water is provided per 24-hour period, and one quart of Gookinaid is also provided in temperatures exceeding 90 °F. Gookinaid provides the following nutrients per 8 fluid ounces: 70 mg Sodium, 100 mg Potassium, 18 mg Vitamin C, 12 grams of carbohydrates, and 45 calories. The daily caloric intake for each field staff employee is generally 3,000 (with daily multi-vitamin/mineral supplements provided as well), but field staff may go up to 24 hours without food in some situations. Consequently, Blue Mountain Family Center/Wilderness Quest would greatly appreciate your candid evaluation of this employee's health, fitness, and ability to work in this type of environment.

Sincerely,
 BMFC/Wilderness Quest Program Director

Note: If you have any questions concerning unusual physical or medical problems for attendance in this program, please feel free to contact our consulting wilderness medical physician:

Dr. Keith Hooker
 Utah Valley Hospital, Emergency Services
 Provo, Utah 84601
 (801) 379-7002

TO BE COMPLETED AND SIGNED BY THE EXAMINING PHYSICIAN OR HEALTH CARE PROFESSIONAL

GENERAL EMPLOYEE INFORMATION				
Employee Name		Date of Birth		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
Height	Weight	Blood Pressure	Vision (Uncorrected) R: 20/___ L: 20/___ B: ___/___	Vision (Corrected) R: 20/___ L: 20/___ B: ___/___
Pulse (Exercise Tolerance Test)		Resting	Comments	
		Exercise	Comments	
		Recovery	Comments	
Elevation of Employee's Residence		Known Allergies to Foods or Medications		

ARE THERE ANY ABNORMALITIES OF THE FOLLOWING SYSTEMS? (PLEASE EXPLAIN FULLY, USING ANOTHER SHEET IF NECESSARY)		
1) Head, Ears, Nose, Throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please explain:
2) Respiratory?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please explain:

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3) Cardiovascular?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please explain:
4) Gastrointestinal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please explain:
5) Eyes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please explain:
6) Hernia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please explain:
7) Musculoskeletal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please explain:
8) Neuropsychiatric?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please explain:
9) Metabolic/ Endocrine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please explain:
10) Skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please explain:

RELATED QUESTIONS AND CONCERNS

1) Is this employee currently on any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please list condition(s), type(s) of medication, and dosage(s). Also, please explain if any medications might compound any heat, cold, or circulation-related conditions (i.e. dehydration, skin problems, etc.):
2) Is this employee under care for a chronic condition or serious illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please explain:
3) Are there any dietary restrictions or recommendations for this employee?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please explain:

Please list any other recommendations or restrictions (if none, please specify "None"): _____

It is the general position of Blue Mountain Family Center/Wilderness Quest that an applicant *should not* be considered for employment if any of the following conditions exist (*please mark below if there is any evidence of these ailments*):

- | | |
|---|--|
| <input type="checkbox"/> Chicken Pox, Measles, or other contagious diseases | <input type="checkbox"/> Mycobacterium Tuberculosis, if contagious |
| <input type="checkbox"/> Hepatitis A, B, or C, if contagious | <input type="checkbox"/> Epilepsy (must be approved by Wilderness Quest) |
| <input type="checkbox"/> Obesity (that would interfere with hiking) | <input type="checkbox"/> Arthritis (if such condition would be aggravated by hiking) |
| <input type="checkbox"/> Knee/ankle injury (that would interfere with hiking) | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Colitis |
| | <input type="checkbox"/> Hypoglycemia |
| | <input type="checkbox"/> Delusions |
| | <input type="checkbox"/> Psychotic |
| | <input type="checkbox"/> Chronic Schizophrenia |

OVERALL APPRAISAL

Upon completion of this examination, I recommend that this employee be:

- Cleared to work at Wilderness Quest with no restrictions
- Cleared to work at Wilderness Quest with the following restrictions (*please explain on a separate sheet of paper*)
- Not cleared to work at Wilderness Quest for the following reasons (*please explain on a separate sheet of paper*)

Examining Physician/Health Care Professional Signature

Date of Examination

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