

COASTLINE CHALLENGES CAMP **MEDICAL HISTORY & PHYSICAL EXAMINATION RECORD**

(to be completed by Physician – confidential when completed)

Please read the following material carefully before completing this medical form.

IF YOU HAVE ANY CONCERNS, PLEASE CALL THE CAMP DIRECTOR OR
INTAKE COORDINATOR AT (250) 384-9133.

COASTLINE CHALLENGES WILDERNESS CAMP IS A YOUTH JUSTICE PROGRAM. WE OFFER A STRUCTURED SEQUENTIAL FORMAT AND OPERATE YEAR-ROUND PHYSICALLY DEMANDING WILDERNESS PROGRAMS IN ALL TYPES OF WEATHER. THE PROGRAMS TYPICALLY INCLUDE RUNNING, JOGGING, PUSH-UPS, QUICK DIPS IN OUTDOOR WATER (even in winter), CANOEING, ALL-TERRAIN HIKING, LIFTING, BALANCING, ROCK-CLIMBING, RAPELLING AND SWIMMING. PARTICIPANTS SLEEP OUTDOORS UNDER IMPROVISED SHELTERS OF THEIR OWN MAKING. PARTICIPANTS CARRY HEAVY PACKS AND MAY TRAVEL TO ALTITUDES OF UP TO 7000 FEET. A 48-HOUR SOLO EXERCISE IS INCLUDED AFTER 2 FULL WEEKS OF SKILL DEVELOPMENT.

Coastline Challenges will provide suitable equipment, clothing and ample meals. Special dietary requirements can usually NOT be met. Participants are expected to refrain from the use of alcohol, drugs and other stimulants or depressants during the program. A NO SMOKING policy is in effect.

Any male (13 years or over) with normal physical and mental capacity can usually expect to be capable of completing the Coastline Challenges program. Preliminary conditioning is strongly advised. The program will decline any applicant whose medical condition is not suitable for the course.

We urge that you be thorough in providing Coastline Challenges Wilderness Camp program with the information requested. Over the years, many youth who have had a variety of medical/psychological difficulties have attended and successfully completed our program, but we must be aware of these conditions for the applicant's benefit and safety. Failure to disclose such information could result in harm to the applicant or other participants.

Note: The applicant and his guardian have been requested to sign a release form regarding the following information.

PLEASE RETURN THE COMPLETED MEDICAL FORM TO:
COASTLINE CHALLENGES CAMP, 1240 Yates Street, Victoria, B.C. V8V 3N3
PHONE: (250) 384-9133 FAX: (250) 384-9136

COASTLINE CHALLENGES CAMP --- MEDICAL HISTORY

Name of youth: _____

Care Card # _____

Height _____

Weight _____

Circle or check all that apply (or have applied) to this youth:

Comments:

- Hepatitis, H.I.V., Tuberculosis, other infectious condition _____
- Diabetes, Epilepsy _____
- Thyroid, liver or kidney conditions _____
- Vision impairment or requires glasses _____
- Hearing impairment _____
- Dizzy spells, fainting, convulsions, persistent headaches _____
- Motion sickness _____
- Frequent infections of throat, tonsils, sinuses, or ears _____
- Chronic cough, bronchitis, bloody sputum _____
- Asthma – allergy induced / exercise induced _____
- Chest pains on exertion _____
- Palpitation of the heart, irregular heart beat, heart murmurs _____
- Poor circulation – gets cold easily _____
- Low or high blood pressure _____
- Nausea, vomiting, food intolerances, heartburn _____
- Diarrhea or blood in the stool _____
- Hernia _____
- Urination difficulty: enuresis, burning or frequency _____
- Kidney infection or stones _____
- Pain in neck, back, shoulders, arms or legs _____
- Broken bones, joint dislocations, serious sprains, weak muscles _____
- Joint pains, swelling or stiffness without injury _____
- Injury to head, chest, internal organs _____
- Chronic skin problems – rashes, hives _____
- Fear of heights, claustrophobia, agoraphobia _____
- Dietary restrictions or food allergies _____
- Continuing use of alcohol or drugs _____
- Episodes of depression or anxiety _____
- Any other health concerns** _____

MEDICATION

Is youth currently on medication? ___ YES ___ NO

If yes, name and dosage _____

Medication brought to program must be accompanied by dosage instructions.
Instructors will carry all medications (properly labeled with youth's name) for security reasons but participants will be responsible for administering their own dosages.

MENTAL HEALTH & DRUG USE

Is the applicant now under treatment of a psychologist or psychiatrist? ___ YES ___ NO

If yes, give his/her name _____ Phone _____

Has the applicant received psychiatric treatment in the past? _____

If yes, give details _____

Has the applicant had, or does he presently have, a **drug related problem**? ___ YES ___ NO

If yes, give details _____

OTHER

Date or year of last tetanus immunization _____ ___ Unknown

What is the applicant's current level of physical activity? _____

How long have you known the applicant? _____

Do you feel that further examination by a specialist is indicated? ___ YES ___ NO

If yes, what kind of specialist? _____

ON THE BASIS OF YOUR PAST KNOWLEDGE, THE APPLICANT'S MEDICAL HISTORY AND THE PRESENT EXAMINATION, DO YOU FEEL THIS INDIVIDUAL CAN PARTICIPATE IN THE COASTLINE CHALLENGES PROGRAM? ___ YES ___ NO

Name of examining physician _____

Signature _____

Address _____

Phone _____

Date _____