Pioneer Handcart Trek Medical Release Form

This form must be completed and signed by a medical doctor for participants who answered "yes" to any of the conditions listed on the Medical History portion of the Registration form. They will not be allowed to participate if this form is not submitted. The examination must be current within six weeks of the participation date.

Participant _____ Date of Conference_____

Dear Doctor: The above named person will participate in a Pioneer Youth Conference. Persons suffering from any of the conditions listed below must obtain a physician's clearance before participating in this program. The participants will be in a wilderness setting for four days. They will have ample food and water. On the **first day** they will hike approximately 8 to 11 miles on varying terrain. On subsequent days they will hike approximately 2 to 4 miles on varying terrain and engage in other outdoor activities. Please consider the following conditions in your decision (as well as other medical problems which may be aggravated by or interfere with the aforementioned conditions):

Arthritis
Emotional problems requiring medication
Major bone or joint injuries
Major operation or serious illness
Diabetes
Pregnancy
Hypoglycemia
Asthma
Epilepsy
Fainting spells
Ulcers
Rheumatic fever
High blood pressure
Heart trouble
Other medical conditions which might be aggravated by hiking

Due to the strenuous physical nature of Pioneer Trek Youth Conference, individuals suffering from aggravating medical conditions are not to be allowed to participate in some of the regular **first day's** activities. However, these individuals still need your approval to participate in subsequent outdoor activities and hiking where medical facilities are limited.

Individuals will be allowed to take medications for chronic conditions if the medication is prescribed or accompanied by a doctor's approval.

General Appraisal:
( ) APPROVAL: I find no medical problems which I consider incompatible with this program.
( ) LIMITED APPROVAL: This individual may participate subject to the limitations listed below.
( ) DISAPPROVAL: This individual has medical problems which, in my opinion, clearly constitute unacceptable hazards to his/her health and safety in this program.

Recommendations and/or restrictions: (if none, specify)_____
_____
_____

Date _____ Signature_____

Doctor's Name (print)_____Phone_____
Address)
_____