# the WOLVES and MOOSE of isle royale

# Research Expedition Health Form

Dear Participant,
This health form is an important part of signing up. Without this form and a signature from an appropriate medical official, we cannot permit you to participate on this expedition. After filling out this form completely and accurately, take it and the information on our *Join a Moosewatch Expedition* webpage to a health care provider. Ask you health care provider to read the sections that detail the *nature and difficultly of the expedition*. To verify that you are able to participate, ask the health care provider to sign the last page of this form. The form may be signed by a medical doctor, physician's assistant, or nurse practitioner. If you develop any medical conditions after submitting this form, notify us immediately.

This form is important for ensuring that you will be able to successfully participate and to help us help you should a medical emergency arise during the expedition. If upon reviewing your health form we have concerns about your ability to participate on this expedition, we will call you to discuss whether this trip is appropriate for you. All medical information provided here is confidential and will be known only to the leaders of the wolf-moose project.

PARTICIPANT NAME:_____

Have you ever had any of the following conditions? Please check all that apply and use the space at the bottom of this page to describe additional details.

| | | |
|---|---|---|
| ☐ Active Hepatitis Type: | ☐ Epilepsy / seizures | ☐ Skin conditions |
| ☐ Anemia | ☐ Head injury | ☐ Kidney or liver condition |
| ☐ Cancer | ☐ Headaches/migraines | ☐ Musculoskeletal condition (osteoporosis, fibromyalgia, etc) |
| ☐ Chronic lung condition | ☐ Heart condition (e.g., disease, murmur, irregularity) | ☐ Orthopedic problems (sprains, strains, fractures) |
| ☐ Chronic back condition | ☐ Heat or cold sensitivity | ☐ Tuberculosis, exposure to TB |
| ☐ Dizziness/balance condition | ☐ High blood pressure | ☐ Stomach/intestinal conditions |
| ☐ Eating disorder | ☐ Immune system condition | ☐ Joint condition (arthritis, bursitis, etc.) |
| ☐ Endocrine / thyroid condition | | |

☐ Yes ☐ No ☐ N/A If you have asthma, can you self medicate?

☐ Yes ☐ No ☐ N/A If you have diabetes/hypoglycemia, can you self-medicate?

☐ Yes ☐ No Have you ever been hospitalized or had surgery? If yes, please include details below.

☐ Yes ☐ No Have you ever been diagnosed with a learning disability? If yes, please include details below as they relate to needs you may have during the expedition.

☐ Yes ☐ No Do you have any allergies (include drugs, food, insect stings, etc.)? If yes, please include details below.

☐ Yes ☐ No Do you smoke?

☐ Yes ☐ No Do you have any conditions that are not already listed above?

*If you have checked any of the conditions above please provide details below.*

*If there is not enough space please attach additional pages.*

Vision and hearing:

☐ Yes ☐ No Do you have difficulty seeing in low light conditions or have unusual difficulties at night?

☐ Yes ☐ No Do you have color blindness?
provide details:

☐ Yes ☐ No Do you have glaucoma, macular degeneration, cataracts or other visual impairment? If yes, please

☐ Yes ☐ No Do you wear corrective lenses?

☐ Yes ☐ No Are you hearing impaired? If yes, please describe to what extent (e.g., corrected to what percent with hearing aid, hear no sound, difficulty hearing with background noise, require sign language, read lips, need TTY/TDD):

Mental Health:

☐ Yes ☐ No Have you ever been diagnosed with or been treated for a psychiatric condition, such as bipolar disorder or depression? If yes, please provide details:

☐ Yes ☐ No Have you been in counseling with a psychiatrist or psychologist within the past 2 years? Reason for counseling:

Medications:

☐ Yes ☐ No Do you take any prescription or non-prescription medications? If yes, please list the medication, reason for taking it, and length of time you've been taking it.

Current level of physical activity

Please check the box that applies to you.

| Activity | Frequency | Time / distance | Relaxed | Moderate | Intense |
|---|---|---|---|---|---|
| walking | | | ☐ | ☐ | ☐ |
| running | | | ☐ | ☐ | ☐ |
| swimming | | | ☐ | ☐ | ☐ |
| other (specify) | | | ☐ | ☐ | ☐ |
| other (specify) | | | ☐ | ☐ | ☐ |

| Stamina | Easily | Moderately well | With difficulty | Not at all |
|---|---|---|---|---|
| Before tiring I can walk 1 mile (1.6 km). | ☐ | ☐ | ☐ | ☐ |
| Before tiring I can walk 5 mile (8 km). | ☐ | ☐ | ☐ | ☐ |
| I can hike 3 hours over rough terrain. | ☐ | ☐ | ☐ | ☐ |
| I can hike 3 hours over rough terrain with a 40lb (18 kg) pack. | ☐ | ☐ | ☐ | ☐ |

Swimming: What is your swimming ability?

☐ non-swimmer ☐ recreational swimmer ☐ strong swimmer ☐ current water life-saving certificate

**Participant Affirmation**

I understand the physical demands of the expedition for which I have signed up. I have reviewed this form and the description of the expedition's conditions and difficulty with my medical care provider. I have answered all the questions on this form truthfully and completely.

PARTICIPANT SIGNATURE:_____ DATE:_____

**To the Doctor or medical care provider,**

We, the leaders of the wolf-moose research project, have been conducting these expeditions for more than 20 years. More that 400 people have participated in these expeditions for which your patient is now planning to participate. Please review the sections of *Join a Moosewatch Expedition* that detail the ***nature and difficulty of the expedition***. After discussing the expedition's physical demands and health risks with your patient, if you feel that your patient is fit and able to fully participate, please fill out the information and sign below.

| | |
|---|---|
| Patient Name: | |
| Examination date: | |
| Patient information | Accurate Height: Accurate Weight: |
| How long have you known the patient? | |
| Name and title of examiner: | |
| Address: | |
| Telephone: | |
| Comments: | |

I have reviewed the health risks and physical demands for this expedition, and believe that my patient is in good health and able to fully participate on this expedition. I am not related to the patient in any way that would represent a conflict of interest.

EXAMINER'S SIGNATURE:_____ DATE:_____

The participant should mail this form, when completed, to:

Ken Vrana, Expedition Coordinator
Isle Royale Institute - Michigan Tech
1400 Townsend Dr.
Houghton, MI 49931