

CÉGEP DE LA GASPÉSIE ET DES ÎLES

ADVENTURE TOURISM PROGRAM

STUDENT MEDICAL EXAMINATION CERTIFICATE

To the Physician: The bearer of this medical certificate has applied to the Cégep de la Gaspésie et des Îles to attend an outdoor activity training course. The purpose of this course is to train participants in a high level performance in various outdoor pursuit activities including, but not limited to: white water canoeing and kayaking, sea kayaking, hiking and backcountry skiing.

This program includes very strenuous physical and psychological activities for long periods of time. As a student in Adventure Tourism, he/she will be required to lead groups of 6-20 people, in potentially stressful situations and physical environments. Therefore, the student should be psychologically capable to handle a high level of physical, emotional and psychological stress. Please make your examination and comments with the previous information in mind. Thank you.

- | 1. The applicant has already be affected with: | Yes | No |
|---|--------------------------|--------------------------|
| a. Previous fractures or dislocations | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Repetitive stress/ chronic injuries (knees, shoulders, back) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Hernia | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Heart disease | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Other previous illnesses | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Previous surgery | <input type="checkbox"/> | <input type="checkbox"/> |

If the answer is yes to any of the above, please explain.

- | 2. The applicant is subject to: | Yes | No |
|--|--------------------------|--------------------------|
| a. Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Fainting | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Hay fever | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Ear infection | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Other | <input type="checkbox"/> | <input type="checkbox"/> |

If the answer is yes to any of the above, please explain.

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- | 3. General information | Yes | No |
|---|--------------------------|--------------------------|
| a. In the last two years, has the applicant had treatment for mental illness (depression, anxiety, eating disorders, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If yes, is he/she now considered stable and recovered? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Does the applicant appear to take stress well? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Does the applicant ever abuse alcohol or drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Does the applicant ever have an addiction? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Does the applicant have any physical or psychological limitations? | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, please explain _____

4. Vaccinations / inoculations which are required. Please indicate vaccination date received.

a. Diphtheria-tetanus (booster within last 10 years) _____

5. Medications and dosage

a. _____

b. _____

c. _____

- | | Yes | No |
|--|--------------------------|--------------------------|
| 6. Does the participant have a reaction to any medications? | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, which medications? _____

- | | | |
|--|--------------------------|--------------------------|
| 7. Does the participant or anyone in his/her family have a reaction to anaesthetic? | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, please explain. _____

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8. Physical exam

a. Height: _____

b. Weight: _____

c. B.P.: _____

d. Pulse: _____

N A

e. ORL

f. Neck

g. Heart

h. Lungs

i. Abdomen

j. Limbs / back

k. Neuro

Yes No

l. Vision _____ Colour vision

Test used _____

m. Are glasses or contact lenses used?

n. Hearing _____

o. Urinalysis: Albumin _____ Sugar _____

9. Overall Fitness _____

10. General comments _____

Being aware of the program requirements for this student, I believe he/she is:

Fit ____ (**Initials of Physician**) Unfit ____ (**Initials of Physician**) to take this training.

For how long has the Physician known the patient? _____

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Physician's name (please print) _____

Physician's signature _____

Address: _____

Phone: _____

To be completed by a Physician. Please send this document directly to:

Collège de la Gaspésie et des Îles

Adventure Tourism program

96, Jacques Cartier St., Gaspé, Québec, G4X 2S8

Telephone: (418) 368-2201

STUDENT AUTHORIZATION (*MUST BE SIGNED IN FRONT OF THE PHYSICIAN*)

I hereby authorized the Physician to transmit any pertinent medical information about me. Furthermore, once this document returned to the Cégep de la Gaspésie et des Îles, I authorize persons who have rights to consult it, to transmit any health information to a medical practitioner should an accident, or any medical issue related to my health arises.

I also understand that two copies of this document may be kept by the Cégep de la Gaspésie et des Îles. One in the student file's of the Cégep administration and one in a sealed briefcase of a program instructor.

Date: _____

Student name (please print) _____

Student signature _____