

Allergies:

Drugs: _____ Food: _____

Other: _____

Medications:

Do you have any present or past conditions or injuries that may affect your ability to participate in the One Family Fund Cross Israel Hike?

Do you have any of the following: Please circle YES (Y) or NO (N)

EPILEPSY Y / N HEART CONDITION Y / N

ASTHMA Y / N DIABETES Y / N

Do you wear glasses: Y / N Do you wear contacts: Y / N

Other: _____

Any health information that the organizers should be aware of:

MEDICAL INFORMATION

YES NO

1. Has your doctor ever said that you have a heart condition and that you should only engage in physical activity when recommended by a doctor?
2. Do you feel pain in your chest when you do physical activity?
3. In the past month, have you had chest pain when you were not doing physical activity?
4. Do you lose your balance because of dizziness or do you ever lose consciousness?
5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your level of physical activity?
6. Are you currently taking any prescriptions for high cholesterol, your blood pressure or a heart condition?

7. Do you know of any other reason why you should not engage in strenuous physical activity?

8. Do you currently smoke (tobacco) 1 or more times per week?

9. Do you engage in less than 30 minutes of moderate physical activity most days of the week?

10. Are you currently pregnant?

11. Are you aware of any other medical reason why you should not participate in the Cross Israel Hike?

____I certify that the above information is correct to the best of my knowledge

Signature:_____Date_____

THIS IS MY MEDICAL CLEARANCE FORM SIGNED BY A PHYSICIAN THAT WILL ALLOW ME TO PARTICIPATE IN THE ONE FAMILY FUND 2011 CROSS ISRAEL HIKE. I HEREBY AUTHORIZE THE ORGANIZERS OF THE HIKE TO RELEASE MY MEDICAL INFORMATION TO THE MEDICAL SUPERVISOR OF THE EVENT AND TO ANY THIRD PARTY GIVING TREATMENT TO ME, AT THE SOLE AND ABSOLUTE DISCRETION OF THE ORGANIZERS.

Signature of Participant

Date

If you answered "YES" to any of the above Medical Questions, please continue with Part B; If all answers are "NO" please continue below.

TO BE COMPLETED BY A PHYSICIAN

I hereby certify that the above information is correct. I understand that:

- the trip is physically demanding and requires the participant to be extremely agile, fit and in superior cardio-condition
- the terrain is steep and narrow and some areas have a significant elevation gain.
- An alternative, Gentle Excursion Level is available for participants who so desire or require, walking for 2-3 hours per day over less challenging terrain, requiring basic cardio, endurance, strength and agility. Participants would have to be able to carry a backpack weighing approximately 10-15 lbs. containing two litres of water and other necessities in possible extreme heat.
- The hiking trail is not accessible by ambulance and in case of extreme emergency, a helicopter would airlift the patient to the nearest hospital.

By signing this form you are confirming that your patient can handle the challenges described above.

I hereby certify that the above information is correct to the best of my knowledge and that the Hiker / Volunteer (name) _____ is medically capable of participating in the 2011 ONE FAMILY FUND CROSS ISRAEL HIKE.

Any additional comments:

Physician's Name: _____

Physician's Address: _____

Office Phone: _____

Office Fax: _____

Physician's Signature

Date

Medical Stamp

PART B:

Following is a checklist of medical conditions, based on responses to the questions on page 3, to help identify individuals who might be at medical risk and therefore should not participate in the One Family Fund Cross Israel Hike.

To the physician: Please check all that apply

	Absolute Contraindications	Relative Contraindications	Special Prescriptive Conditions
Cardiovascular	___aortic aneurism (dissecting) ___aortic stenosis (severe) ___congestive heart failure ___crescendo angina ___myocardial infarction (acute) ___myocarditis (active or recent) ___pulmonary or systemic embolism-acute ___thrombophlebitis ___ventricular tachycardia and other dangerous dysrhythmias (e.g. multi-focal ventricular activity)	___aortic stenosis (moderate) ___subaortic stenosis (severe) ___marked cardiac enlargement ___supraventricular dysrhythmias (uncontrolled or high rate) ___ventricular aneurysm ___hypertension-untreated or uncontrolled severe (systemic or pulmonary) ___hypertrophic cardiomyopathy ___compensated congestive heart failure	___aortic (or pulmonary)stenosis-mild angina pectoris and other manifestations of coronary insufficiency (e.g. post-acute infact) ___cyanotic heart disease ___shunts (intermittent or fixed) ___conduction disturbances -complete AV block -left BBB Wolff-Parkinson-White Syndrome ___dysrhythmias-controlled ___fixed rate pacemakers ___intermittent claudication ___hypertension: systolic 160-180; diastolic 105+
Infections	___acute infections disease (regardless of etiology)	___subacute/chronic/recurrent infectious diseases (e.g., malaria, others)	___chronic infections ___HIV
Metabolic		___uncontrolled metabolic disorders (diabetes mellitus, thyrotoxicosis, myxedema)	___renal, hepatic & other metabolic insufficiency ___obesity ___single kidney
Lung			___chronic pulmonary disorders ___obstructive lung disease ___asthma ___exercise-induced bronchospasm
Musculoskeletal			___low back conditions (pathological, functional) ___arthritis-acute (infective, rheumatoid; gout) ___arthritis-subacute ___arthritis-chronic (osteoarthritis and above conditions) ___orthopaedic

			<input type="checkbox"/> hernia <input type="checkbox"/> osteoporosis or low bone density
CNS			<input type="checkbox"/> convulsive disorder not completely controlled by medication <input type="checkbox"/> recent concussion
Blood			<input type="checkbox"/> anemia-severe (<100 Gm/l) <input type="checkbox"/> electrolyte disturbances
Medications			<input type="checkbox"/> antianginal <input type="checkbox"/> antihypertensive <input type="checkbox"/> antiarrhythmic <input type="checkbox"/> anticonvulsant <input type="checkbox"/> beta blockers <input type="checkbox"/> digitalis preparations <input type="checkbox"/> diuretics <input type="checkbox"/> ganglionic blockers <input type="checkbox"/> others
Other			<input type="checkbox"/> post-exercise syncope <input type="checkbox"/> heat intolerance <input type="checkbox"/> temporary minor illness <input type="checkbox"/> cancer

To be completed by a physician:

I hereby certify that the above information is correct to the best of my knowledge, and advise that Hiker/Volunteer

Name _____ should _____ should NOT

participate in the One Family Fund Cross Israel Hike.

Any additional comments: _____

Physician's Name: _____

Physician's Address: _____

Office phone: _____ Officefax: _____

Physician's signature _____ Date _____

Medical Stamp: _____

