LAKE CHAMPLAIN MARITIME MUSEUM

Lake Champlain Maritime Museum
2023 Summer Expeditions

Physical Examination

Name of Participant: _____

Daytime Phone: _____ Evening Phone: _____

Height: _____ Weight: _____ Sex: _____ Gender Identity: _____ Age: _____

Physical examination data cannot be more than a year old from the starting date of the participant's expedition. **The participant's tetanus immunization must be current (within 10 years) of the start date of the expedition.**

Medical provider must read and fill out the following. Providers can include physician, nurse practitioner, or physician's assistant.

Blood Pressure: _____ Pulse: _____ Last Tetanus Inoculation: _____

General Medical History:

Normal or Abnormal	Area of Examination	Please comment on any abnormalities
	General development	
	Head, face, scalp, skull	
	Eyes	
	Ears, nose/sinus, throat	
	Neck, thyroid	
	Heart	
	Lungs (include asthma)	
	Abdomen (include hernia)	
	Pelvis	
	Extremities	
	Musculoskeletal	
	Lymph glands	
	Neurologic	
	Skin	
	Allergies	

1. Is the individual receiving medical care for a chronic condition or injury? If yes, please explain.

   _____
   _____
   _____

2. Do you have any concerns about the individual's ability to complete the physical rigors of a summer expedition? If yes, please explain.

   _____
   _____
   _____

3. Are there any mental health or emotional concerns to be aware of? If yes, please explain.

   _____
   _____
   _____

4. Any additional comments?

   _____
   _____
   _____
   _____

Expeditions at Lake Champlain Maritime Museum are physically demanding programs. Participants spend up to 14 days living outdoors and including paddling, rowing, sailing, and/or hiking (up to 18 miles in a day) over Lake Champlain. The Museum must be aware of the participant's physical and psychological condition to ensure a safe and enjoyable experience. Based on the description of the program and your examination, do you believe this individual can successfully participant in this expedition?

_____ YES, I believe this individual can successfully participate.

_____ NO, I believe this individual should not participate at this time.

Health Care Provider's Name and Practice: _____

Phone Number: _____ Address: _____

Health Care Provider's Signature: _____ Date: _____