Form D: To be completed by licensed medical personnel (MD, RN, LPN, NP or PA)

Appalachian Mountain Club

Participant Name:___________________________________ Program Dates:____________ - ____________

Age: ________ Gender: ________ Height: ________ Weight: ________ DOB: _______________

□

PHYSICIAN ORDERS FOR PRESCRIPTION MEDICATION: For the AMC to hold and administer prescription meds, orders must be completed, signed by a physician, AND medications must be in original containers per state law.

Is this child on any prescription medications? □ **Yes** □ **No** If YES, Please List Below:

Medication	Condition	Amount Given/Dose	When it is Given (check all applicable)	Initiated (mo/yr)	Side Effects
			□ Breakfast □ Lunch □ Dinner □ Bedtime □ Other Time:_________		
			□ Breakfast □ Lunch □ Dinner □ Bedtime □ Other Time:_________		
			□ Breakfast □ Lunch □ Dinner □ Bedtime □ Other Time:_________		
			□ Breakfast □ Lunch □ Dinner □ Bedtime □ Other Time:_________		

Will the child be carrying an epinephrine auto-injector or rescue inhaler during the trip? Yes, list below □ **No** □

If **YES**, I verify that the child has the knowledge and skills to safely possess and use the epinephrine auto injector or asthma rescue inhaler *listed below,* in a **wilderness setting**. **Please list:**

Medication (Epi-pen/Inhaler)	Condition	Dosage/time of day	Initiated (Mo/Yr)	Side Effects

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- **Has the child received and had updates of all Immunizations? Yes** □ **No** □ Date of last tetanus: _______________
- Has the child had the required physical examination within two years of trip start date? **Yes** □ **No** □
- The child is currently undergoing treatment for the following reasons: ______________________________________
  ____
- This child can participate in physically rigorous activities without restriction: **Yes** □ **No** □
  If NO, please specify accommodations which might allow participation: _________________________________
  ____

Physician Signature *(or other medical personnel)*: ________________________________ **Date:** ____________________

Name of Licensed Provider: ____ **Phone:** ___________________

Licensed Provider Address: ____