Desert RATS
Pre-participation History & Physical

Section 1 (*To be completed by the Desert RATS participant*).

Participant's Name: ____

Age: __________ Sex: M F DOB (mm/dd/yyyy): __________

Please circle yes or no to the following. Be sure to discuss any yes answers with your physician:

1. Are you currently taking any prescription or over the counter medications, supplements, or vitamins?
   Y N
2. Do you have any current injury/illness that may impact your participation in this event? Y N

Section 2 (*To be completed in conjunction with history, physical exam, and any additional assessment modalities as deemed appropriate by a licensed primary care physician or equivalent*).

Please indicate yes or no to the following:

1. Allergies/sensitivities? Y N
2. Current medications/supplements? Y N
3. Active medical conditions requiring care? Y N
4. Pertinent history and physical findings? Y N

Please provide a brief explanation for any yes answers:

____

Recommendations:

- ☐ Cleared for participation in DesertRATS WITHOUT limitations.
- ☐ Cleared for participation in DesertRATS WITH limitations.
- ☐ This patient is NOT cleared for participation in DesertRATS.

I, the undersigned, am licensed to elicit and interpret the medical history, pharmaceutical history and clinical findings of a complete assessment for participation in a strenuous event such as a 6 day adventure ultramarathon. I have completed this assessment and recorded all pertinent findings along with recommendations for participation above.

_______________________________________ ____________

Physician's signature Date completed

_______________________________________ ___________________________________

Stamp or printed name Contact information