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

Please return this form via email to Kyla Claudell (kyla@geminiadventures.com) by June 1.