



CHIPPEWA VALLEY COUNCIL



National Youth Leadership Training

Boy Scouts of America

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Dear Scoutmaster:

DOES YOUR TROOP HAVE MEMBERS READY FOR ADVANCED LEADERSHIP TRAINING?

I am pleased to announce the Chippewa Valley Council will be conducting the National Youth Leadership Training (NYLT) Course June 11-17, 2017 at the L.E. Phillips Scout Reservation near Haugen, Wisconsin. The Course is supported by a team of individuals who are committed to providing your Scout with a high quality leadership training experience that will benefit him, as well as you and your Troop. NYLT provides your Scout with the opportunity to learn from his peers who are a part of our Council's Troops and Crews and who have demonstrated their ability to teach their skills to others. Team development, planning and communication skills, ethical decision making and effective guidance of and interaction with others are just a few of the skills your Scout can expect to gain knowledge of and be able to apply to his home setting as well as use in his future achievements in the world.

The Chippewa Valley Council NYLT Course is designed to supplement the Scoutmaster's efforts by teaching advanced skills using resources not normally available to you. This week long course will offer Scouts and Ventures from across the Council instruction in leadership and will demonstrate specific ways to implement them in your organization. The Scout will return to his home Troop able to apply his new skills in the Troop setting with the assistance of your supervision.

As a part of the commitment to this leadership training Scouts completing the course will be asked to fulfill requirements that extend beyond the course time frame and that allow them to apply the training they receive to their particular setting. Completing this additional work will provide them with other opportunities like being able to apply to the National NYLT Course held each year at Philmont Scout Ranch and the chance to become staff members next year for our local Course.

The application process is simple; Scouts meeting the criteria need to complete the application and turn it in to the Boy Scout Service Center along with the deposit and required information. You, the Scoutmaster, have to endorse the application. All Scouts meeting the age and rank requirements are eligible. Please feel free to copy the enclosed application and pass it on to any Scouts who have met the criteria and you feel would benefit from this experience.

When your Scout returns to his Troop, he will be armed with many new ideas and leadership skills which he is going to be anxious to use and apply. To help you understand these new leadership skills, and their benefit we would like to invite you to observe our Course at any time during the week and will be happy to provide you a chance to meet with your Scout and his Team Guide to discuss how the week is progressing for him and answer any questions you may have about the Course.

National Youth Leadership Training is a continuation of our commitment to the youth of our communities. The leadership training of NYLT gives youth a better foundation for future life experiences. Training Youth to become leaders is what we as Scoutmasters do. Watching them develop into those leaders is our reward. Help us to work together to create tomorrow's leaders.

Yours in Scouting;
Glenn Swanson
Course Director NYLT 2017



National Youth Leadership Training
Boy Scouts of America

L.E. PHILLIPS SCOUT RESERVATION

NYLT REGISTRATION June 11-17, 2017 (Boy Scouts)

PLEASE PRINT

NAME: MY FRIENDS CALL ME:

ADDRESS:

CITY, STATE, ZIP:

HOME PHONE NUMBER: EMERGENCY PHONE NUMBER:

DATE OF BIRTH: Age at time of Course:

TROOP NO: DISTRICT NAME: YEARS IN SCOUTING:

CURRENT LEADERSHIP POSITION: CURRENT RANK:

On my honor as a Scout, I promise that I will live faithfully according to the Scout Oath and Scout Law during the National Youth Leader Training Conference and thereafter. I will represent my Troop with honor and do all I can to pass along my new knowledge and skills to my fellow Scouts. I certify I am at least a First Class Scout, 13 years of age and a Troop Junior Leader, Senior Patrol Leader, Assistant Senior Patrol Leader, or am capable of filling these positions.

SCOUT'S SIGNATURE: DATE:

Scoutmaster's Certification and Approval

I certify that the above named Scout is at least a First Class Scout, 13 years of age, and a Troop Junior Leader at the time of Course. (There are no exceptions to the age and rank guidelines without prior authorization from the Course Director).

SIGNATURE: SCOUTMASTER, TROOP

Scoutmaster Printed Name

Emergency Phone for the Scout Master

Fees: \$50.00 Deposit required to reserve space. Total cost for NYLT Course of \$250.00 due in CVC Scout Office by May 15, 2017 along with completed application and medical information forms.

Fees will be refundable prior to May 26, 2017. After this date the Course Director and the Professional Staff Advisor will process refund requests on a case-by-case basis. Refund requests must be submitted in writing.

Your Troop's Gold Card Discount does apply.

Please Complete Both Sides of form!!!

One activity T-Shirt is included in the Course cost, if you desire additional T-shirts please include \$10.00 per additional shirt, please specify the number of additional shirts and include fee with application.

Additional Shirts? (Yes / No) Quantity _____

Size? Adult: S M L XL

Special Requirements

Please fill out the Medication/Allergy Form with any special food requirements, allergies and/or physical limitations that staff should be aware of so we are able to accommodate these needs for the week you are attending Course. Include daytime contact information in case we have questions or concerns about these requirements. This information is in addition to the required medical form information.

KNOWLEDGE OF OUTDOOR SKILLS

PLEASE CHECK APPROPRIATE COLUMN				
SCOUT SKILL	MERIT BADGE EARNED	NEED HELP	KNOW SOME	HAVE TAUGHT
MAP READING				
COMPASS				
ORIENTEERING				
HIKE PROCEDURES				
HIKING				
CAMPING				
BACKPACKING				
FIRST AID				
SAFE SWIM DEFENSE				
KNIFE AND AXE				
FIRE BUILDING				
COOKING				
KNOTS				
LASHINGS				
PIONEERING				
NATURE				
ENVIRONMENT				
PUBLIC SPEAKING				
ASTRONOMY				

NYLT 2017

Medication/Allergy Form

All participants must fill out and turn in this form by May 15, 2017.

Scout's Name: _____ Medications needed Yes No

If yes, please fill out medication administration section and include all over the counter medications.

Allergy Information:

Medication allergies: _____

Describe Reaction(s): _____

Food/Environmental allergies(Nuts,Bee stings, latex, product specific):

Yes No (If yes, please fill out specific allergy information below.
Include Epi-pens on Medication list.)

Physical Limitations/Accommodations needed: Yes No

If yes, Please describe: _____

Please List all Medications and their dosage

Medication:

Dosage:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
a.m.							
noon							
p.m.							

Medication:

Dosage:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
a.m.							
noon							
p.m.							

Medication:

Dosage:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
a.m.							
noon							
p.m.							

Please put all medications in a Zip-Lock Bag with Scouts name printed on the bag.

NYLT 2017
Medication/Allergy Form

Environmental and Food Allergy (Please fill out if you marked "yes" above)

Food Allergy: _____
Describe reaction: _____
Foods that contain this ingredient: _____
Treatment if exposed: _____

Will the Scout be providing and preparing his own food replacement items? If so, please list what will need to be stored by the Quartermaster. There will be no food/snack items allowed in tents or stored at the campsites.

Environmental Allergies (Nuts, Bee/bug stings, latex, pollen, etc.): _____

Describe reaction: _____

Treatment if exposed (please list all medications above): _____

Parent Signature _____

Emergency Contact Information: (Please Print)

Parents Name: _____
Day Phone: _____
Cell Phone: _____
Night Phone: _____

Scout Master Name: _____
Scout Master Phone: _____
Scout Master Cell: _____
Assist. SM Name: _____
Assist. SM Phone: _____
Assist. SM Cell: _____

Suggested Personal Equipment Checklist

Only the official uniform and parts are acceptable. (Be prepared for an overnight hike as well as living in camp.)

Required

- | | |
|---|---|
| <input type="checkbox"/> Uniform Shirt (short sleeves 1) | <input type="checkbox"/> Required/prescribed medication |
| <input type="checkbox"/> Uniform shorts (1 pair) | <input type="checkbox"/> NYLT Medication Information Sheet |
| <input type="checkbox"/> Uniform Stockings (3 pairs) | <input type="checkbox"/> Class 3 Medical Form |
| <input type="checkbox"/> Official belt and buckle (1) | <input type="checkbox"/> Tote-N-Chip Card |
| <input type="checkbox"/> Neckerchief and woggle | <input type="checkbox"/> Backpack (with frame, if desired) don't have one borrow one |
| <input type="checkbox"/> Shoes suitable for hiking | <input type="checkbox"/> Lightweight tent |
| <input type="checkbox"/> Change of shoes, as desired | <input type="checkbox"/> Plate and bowl |
| <input type="checkbox"/> Raincoat, poncho, or rain suit | <input type="checkbox"/> Knife, fork, and spoon |
| <input type="checkbox"/> Sweatshirt/jacket | <input type="checkbox"/> Canteen/ water bottle |
| <input type="checkbox"/> Underclothing (3 sets, minimum) | <input type="checkbox"/> Ground cloth (waterproof) |
| <input type="checkbox"/> Handkerchiefs (as needed) | <input type="checkbox"/> Sleeping bag/blankets |
| <input type="checkbox"/> Pajamas | <input type="checkbox"/> Air mattress or foam pad |
| <input type="checkbox"/> Change of clothing, as desired | <input type="checkbox"/> Flashlight with spare cells and bulb |
| <input type="checkbox"/> BSA Approved T-shirts | <input type="checkbox"/> Sewing kit/Safety Pins to attach NYLT Shoulder Patch to Uniform |
| <input type="checkbox"/> Work gloves | <input type="checkbox"/> Personal first aid kit |
| <input type="checkbox"/> Towel/Washcloth | <input type="checkbox"/> Ballpoint pen, pencil |
| <input type="checkbox"/> Shampoo and Deoderant | <input type="checkbox"/> Scout knife (No sheath knife) |
| <input type="checkbox"/> Toothbrush and paste | <input type="checkbox"/> Boy Scout handbook |
| <input type="checkbox"/> Comb | <input type="checkbox"/> Compass (official preferred) |
| <input type="checkbox"/> Hand soap and container | <input type="checkbox"/> Laundry soap (small bottle) |

Optional

- | | |
|--|---|
| <input type="checkbox"/> Sharpening stone | <input type="checkbox"/> GPS |
| <input type="checkbox"/> Watch | <input type="checkbox"/> Uniform trousers (1 pair) |
| <input type="checkbox"/> Sunglasses | <input type="checkbox"/> Pillow/case |
| <input type="checkbox"/> Extra prescription eyeglasses | <input type="checkbox"/> Moccasins or slippers |
| <input type="checkbox"/> Religious book(s) | <input type="checkbox"/> Personal scouting equipment |
| <input type="checkbox"/> Sunburn lotion/lip salve | <input type="checkbox"/> Straps and or Fasteners for backback |
| <input type="checkbox"/> Mirror (metal) | <input type="checkbox"/> |
| <input type="checkbox"/> Camera with extra film | <input type="checkbox"/> |
| <input type="checkbox"/> Insect repellent (pump only) | <input type="checkbox"/> |
| <input type="checkbox"/> Uniform long-sleeved shirts | <input type="checkbox"/> |

What not to Bring

- | | |
|---|--|
| <input type="checkbox"/> No electronics | <input type="checkbox"/> No hats |
| <input type="checkbox"/> No Food unless needed for medical condition. | <input type="checkbox"/> No neckerchiefs |
- each Scout will receive a NYLT hat and neckerchief*

** Any special dietary requirements need to be cleared with the NYLT staff prior to attending the course.

Note: Scouts will be in official uniform (the first six items on the required list) upon arrival. A backpack should be used for getting gear from the drop-off point to the campsite. Participants will also need backpacks for the overnight outpost hike. Also, before coming, see that all badges and insignia are properly placed on uniform. **The NYLT Activity T-shirt will be used only on specific days. Scout can wear other BSA activity shirts under their Field Uniform if they choose.**

Part A: Informed Consent, Release Agreement, and Authorization

Full name: _____
DOB: _____

High-adventure base participants:
Expedition/crew No.: _____
or staff position: _____

Informed Consent, Release Agreement, and Authorization

I understand that participation in Scouting activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the venue, activity coordinators, or your local council. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any BSA volunteers or professionals who need to know of medical conditions that may require special consideration in conducting Scouting activities.

With appreciation of the dangers and risks associated with programs and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the local council and the Boy Scouts of America, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all Scouting activities, and I hereby release the Boy Scouts of America, the local council, the activity coordinators, and all employees, volunteers, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the BSA, and I specifically waive any right to any compensation I may have for any of the foregoing.



NOTE: Due to the nature of programs and activities, the Boy Scouts of America and local councils cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that leaders can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.



List participant restrictions, if any: None

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity. If I am participating at Philmont, Philmont Training Center, Northern Tier, Florida Sea Base, or the Summit Bechtel Reserve, I have also read and understand the supplemental risk advisories, including height and weight requirements and restrictions, and understand that the participant will not be allowed to participate in applicable high-adventure programs if those requirements are not met. The participant has permission to engage in all high-adventure activities described, except as specifically noted by me or the health-care provider. If the participant is under the age of 18, a parent or guardian's signature is required.

Participant's signature: _____ Date: _____

Parent/guardian signature for youth: _____ Date: _____

(If participant is under the age of 18)

Second parent/guardian signature for youth: _____ Date: _____

(If required; for example, California)

Complete this section for youth participants only:

Adults Authorized to Take to and From Events:

You must designate at least one adult. Please include a telephone number.

Name: _____

Name: _____

Telephone: _____

Telephone: _____

Adults NOT Authorized to Take Youth To and From Events:

Name: _____

Name: _____

Telephone: _____

Telephone: _____



Part B: General Information/Health History

Full name: _____

High-adventure base participants:

Expedition/crew No.: _____

or staff position: _____

DOB: _____

Age: _____ Gender: _____ Height (inches): _____ Weight (lbs.): _____

Address: _____

City: _____ State: _____ ZIP code: _____ Telephone: _____

Unit leader: _____ Mobile phone: _____

Council Name/No.: _____ Unit No.: _____

Health/Accident Insurance Company: _____ Policy No.: _____



Please attach a photocopy of both sides of the insurance card. If you do not have medical insurance, enter "none" above.



In case of emergency, notify the person below:

Name: _____ Relationship: _____

Address: _____ Home phone: _____ Other phone: _____

Alternate contact name: _____ Alternate's phone: _____

Health History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	Last HbA1c percentage and date:
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	
<input type="checkbox"/>	<input type="checkbox"/>	Adult or congenital heart disease/heart attack/chest pain (angina)/heart murmur/coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers.	
<input type="checkbox"/>	<input type="checkbox"/>	Family history of heart disease or any sudden heart-related death of a family member before age 50.	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	Last attack date:
<input type="checkbox"/>	<input type="checkbox"/>	Lung/respiratory disease	
<input type="checkbox"/>	<input type="checkbox"/>	COPD	
<input type="checkbox"/>	<input type="checkbox"/>	Ear/eyes/nose/sinus problems	
<input type="checkbox"/>	<input type="checkbox"/>	Muscular/skeletal condition/muscle or bone issues	
<input type="checkbox"/>	<input type="checkbox"/>	Head injury/concussion	
<input type="checkbox"/>	<input type="checkbox"/>	Altitude sickness	
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/psychological or emotional difficulties	
<input type="checkbox"/>	<input type="checkbox"/>	Behavioral/neurological disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders/sickle cell disease	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells and dizziness	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	Last seizure date:
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal/stomach/digestive problems	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue	
<input type="checkbox"/>	<input type="checkbox"/>	Obstructive sleep apnea/sleep disorders	CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	List all surgeries and hospitalizations	Last surgery date:
<input type="checkbox"/>	<input type="checkbox"/>	List any other medical conditions not covered above	



Part B: General Information/Health History

Full name: _____
 DOB: _____

High-adventure base participants:
 Expedition/crew No.: _____
 or staff position: _____

Allergies/Medications

Are you allergic to or do you have any adverse reaction to any of the following?

Yes	No	Allergies or Reactions	Explain	Yes	No	Allergies or Reactions	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Medication		<input type="checkbox"/>	<input type="checkbox"/>	Plants	
<input type="checkbox"/>	<input type="checkbox"/>	Food		<input type="checkbox"/>	<input type="checkbox"/>	Insect bites/stings	

List all medications currently used, including any over-the-counter medications.

CHECK HERE IF NO MEDICATIONS ARE ROUTINELY TAKEN. IF ADDITIONAL SPACE IS NEEDED, PLEASE INDICATE ON A SEPARATE SHEET AND ATTACH.

Medication	Dose	Frequency	Reason

YES NO Non-prescription medication administration is authorized with these exceptions: _____

Administration of the above medications is approved for youth by:

_____/_____
 Parent/guardian signature MD/DO, NP, or PA signature (if your state requires signature)

!

Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.

!

Immunization

The following immunizations are recommended by the BSA. Tetanus immunization is required and must have been received within the last 10 years. If you had the disease, check the disease column and list the date. If immunized, check yes and provide the year received.

Yes	No	Had Disease	Immunization	Date(s)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pertussis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Measles/mumps/rubella	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Influenza	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (i.e., HIB)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exemption to immunizations (form required)	

Please list any additional information about your medical history:

DO NOT WRITE IN THIS BOX
 Review for camp or special activity.

Reviewed by: _____

Date: _____

Further approval required: Yes No

Reason: _____

Approved by: _____

Date: _____

Part C: Pre-Participation Physical

This part must be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants.

Full name: _____

DOB: _____

High-adventure base participants:

Expedition/crew No.: _____
or staff position: _____



You are being asked to certify that this individual has no contraindication for participation inside a Scouting experience. For individuals who will be attending a high-adventure program, including one of the national high-adventure bases, please refer to the supplemental information on the following pages or the form provided by your patient.



Examiner: Please fill in the following information:

		Yes	No	Explain							
Medical restrictions to participate		<input type="checkbox"/>	<input type="checkbox"/>								
Yes	No	Allergies or Reactions		Explain		Yes	No	Allergies or Reactions		Explain	
<input type="checkbox"/>	<input type="checkbox"/>	Medication				<input type="checkbox"/>	<input type="checkbox"/>	Plants			
<input type="checkbox"/>	<input type="checkbox"/>	Food				<input type="checkbox"/>	<input type="checkbox"/>	Insect bites/stings			
Height (inches): _____		Weight (lbs.): _____		BMI: _____		Blood Pressure: _____ / _____		Pulse: _____			

	Normal	Abnormal	Explain Abnormalities
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Ears/nose/throat	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Genitalia/hernia	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a Scouting experience. This participant (with noted restrictions):

True	False	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Meets height/weight requirements.
<input type="checkbox"/>	<input type="checkbox"/>	Does not have uncontrolled heart disease, asthma, or hypertension.
<input type="checkbox"/>	<input type="checkbox"/>	Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.
<input type="checkbox"/>	<input type="checkbox"/>	Has no uncontrolled psychiatric disorders.
<input type="checkbox"/>	<input type="checkbox"/>	Has had no seizures in the last year.
<input type="checkbox"/>	<input type="checkbox"/>	Does not have poorly controlled diabetes.
<input type="checkbox"/>	<input type="checkbox"/>	If less than 18 years of age and planning to scuba dive, does not have diabetes, asthma, or seizures.
<input type="checkbox"/>	<input type="checkbox"/>	For high-adventure participants, I have reviewed with them the important supplemental risk advisory provided.

Examiner's Signature: _____ Date: _____

Provider printed name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Office phone: _____

Height/Weight Restrictions

If you exceed the maximum weight for height as explained in the following chart and your planned high-adventure activity will take you more than 30 minutes away from an emergency vehicle/accessible roadway, you may not be allowed to participate.

Maximum weight for height:

Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight	Height (inches)	Max. Weight
60	166	65	195	70	226	75	260
61	172	66	201	71	233	76	267
62	178	67	207	72	239	77	274
63	183	68	214	73	246	78	281
64	189	69	220	74	252	79 and over	295

