

**Trek 2024 Farmington Utah Stake**  
**July 10-13, 2024**  
***MEDICAL RELEASE FORM***

Participant: \_\_\_\_\_

**IMPORTANT:** This form needs **ONLY** be completed and signed by a medical doctor for participants who answered "yes" to any of the conditions listed on the **TREK REGISTRATION form**. We need each participant to submit this form before attending Trek. The examination must be current within six weeks of the participation date.

Dear Doctor:

The above-named person will participate in a Farmington Utah Stake Trek 2024. Persons suffering from any of the following conditions must obtain a physician's clearance before participating in this program. The participants will be outside and walking for the majority of the three day period. They will be provided with ample water and food. Please consider the following conditions in your decision:

Asthma (serious conditions)	Epilepsy	
Arthritis		Fainting spells
Emotional problems requiring medication	Ulcers	
Major bone or joint injuries	Rheumatic Fever	
Major operation or serious illness	Diabetes/Hypoglycemia	

Any other medical condition or problems which may be aggravated or interfere with, the aforementioned conditions?

Due to the physical nature of the Farmington Utah Stake Trek 2024, individuals suffering from Diabetes, Hypoglycemia, Serious Obesity, Heart Trouble, or High Blood Pressure may not be allowed to participate in some of the activities. However, these individuals still need your approval to participate in an outdoor experience where medical facilities are limited.

Individuals will be allowed to take medications for chronic conditions if the medication is prescribed or accompanied by a doctor's approval.

General Appraisal:

- Approval -- I find no medical problems that I consider incompatible with this program.
- Disapproval -- This individual has medical problems which, in my opinion, clearly constitute unacceptable hazards to his/her health and safety in this program.

Recommendations and/or restrictions: *(if none, specify)* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
*(Doctor's Name)*

\_\_\_\_\_  
*(Doctor's Signature)*

\_\_\_\_\_  
*(Date)*

\_\_\_\_\_  
*(Doctor's Address)*

\_\_\_\_\_  
*(Phone)*