



Physician's Consent

This form is required of all Hante participants.
Please complete and upload by April 1st.

To the Hante Participant,

Since your Hante course will be both physically and mentally demanding your physician needs to understand what a Hante program is all about when they perform your physical. Please show this to your doctor when you receive your physical. Your signed and completed medical form, along with this signed letter, is due by April 1st. Thank you for your help.

To the Physician,

Your patient is planning to participate in a backpacking and outdoor activity course with Hante Adventures this summer. Some Hante Adventurers will be traveling, backpacking, and hiking in other countries. During the course, the participant will experience long and hard days and may carry a pack of 25-50 pounds (depending on their own body weight). The participant will be traveling great distances, camping in a tent or tarp, and sleeping on the ground in remote areas with limited access to medical care for the majority of the two to three week trip. They may also be rock climbing or white or flat water canoing in chilly water. A Hante Adventures course is strenuous and requires that the participant be in good health, is physically fit, and is ready for a challenge.

Physician, please complete the following:

I understand that _____ is planning to participate in the activity described above and I have found that they are in good health and has no injuries, illnesses, or conditions that would impair their ability to participate.

Physician Signature: _____

Date: _____

Only Complete this portion if your child sees a medical specialist, please have that specialist sign this form as well. Examples of specialists include, but are not limited to, orthopedist, neurologist, cardiologist, endocrinologist, psychiatrist.

I understand that _____ is planning to participate in the activity described above and I have found that they are in good health and has no injuries, illnesses, or conditions that would impair their ability to participate.

Physician Signature: _____

Date: _____