OUTWARD BOUND

2 PAGE YOUTH MEDICAL RECORD

RETURN

OFFICE USE ONLY

FOLLOW-UP

APPROVAL

INSTRUCTIONS All the questions on this form are important. The answers are needed in order to assess your level of participation in the program. Please answer every question in every section and return the form as soon as possible, in order to allow time for any needed follow-up. Incomplete forms will slow down the screening process, and may cause you to miss out on your Outward Bound program. Please write legibly in blue or black ink.

PART I – GENERAL INFORMATION

PROGRAM/COURSE NUMBER: _____ **START DATE:** _____

Applicant

Name: _____ Age at Program Start: _____ DOB: _____

Address: _____ Height: _____ ft. _____ inches Weight: _____ lbs.

City/State/Zip: _____ Sex identified as: ❑ Male

Home Phone: _____ ❑ Female

Cell Phone: _____ ❑ _____

E-mail: _____

Parent/Custodial Guardian (if applicant is under the age of 18)

Name: _____ Relationship to Applicant: _____

E-mail: _____ Occupation: _____

Address: _____ City/State/Zip: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____

Emergency Contact (not a parent or guardian)

Name: _____ Relationship to Applicant: _____

Home Phone: _____ Cell or Work Phone: _____

Ethnic Background (optional)

❑Asian ❑Caucasian (Non-Hispanic) ❑American Indian/Alaskan Native

❑Multi-Ethnic ❑Native Hawaiian or Pacific Islander ❑Do Not Know Ethnicity

❑Hispanic or Latino ❑African American ❑Other: _____

Insurance Information

If you have insurance, please attach a photocopy of both the front and back of your insurance card. ***Each participant is responsible for any medical expenses and should be covered by his/her own illness and accident insurance.***

PART II – MEDICAL INFORMATION

A. **ALLERGIES** Include allergies to medications, foods, insect bites/stings, environmental, etc.

Allergy List Below	**Reaction** List Below	**Medications Required** (if any)

B. **MEDICATIONS YOU ARE CURRENTLY TAKING** If psychiatric medication, please list any medications taken or changed within the past 3 months. Also list any over-the-counter, inhalers, herbal supplements, etc.

Medication List Below	**Taken For** Symptom/Condition	**Dosage** Size/Frequency	**Date Started**	**Current Side Effects** (if any)

NOTE: If you are taking prescription medications, you MUST bring them in ORIGINAL PRESCRIPTION BOTTLES with the physician's dosage directions. If possible, bring a double supply. If there are any changes please contact Outward Bound.

C. **CURRENT EXERCISE ACTIVITY** List your current physical activity (if any). You will be expected to engage in rigorous physical activity during your Outward Bound experience. It is vital that you start (or continue) a physical fitness routine in preparation for the program!

Activity	Frequency	Time/Distance	Leisurely	Moderately	Intensely

PART III – HEALTH PROFILE

Do any of the following apply to you? If YES check the box next to the item and provide details on the spaces below.

- ❑ Asthma (If yes, bring inhaler)
- ❑ Bedwetting
- ❑ Cardiac conditions, e.g., heart murmur or other rhythm abnormality
- ❑ Current orthopedic problems (neck/back/knee/shoulder)
- ❑ Currently pregnant
- ❑ Special diet
- ❑ Hospitalization or Emergency Room visit within past year
- ❑ Seizure within the past 6 months
- ❑ Unexplained chest pain/pressure, shortness of breath, rapid heartbeat, sweats, dizziness or faint spells
- ❑ Use of tobacco
- ❑ Other medical issues, illnesses, symptoms, requirements, or prosthetic device(s)

Describe: _____

Describe: _____

Blood Pressure: _____ Date Taken: _____ (Must be within 1 year of course start)
Blood pressure may be taken with apparatus at a local grocery or drug store.

PART IV – PERSONAL HISTORY based on the past one year.

Do any of the following apply to you? If YES check the box next to the item and provide details on the spaces below.

- ❑ ADHD
- ❑ Anxiety Disorder
- ❑ Depressive Disorder
- ❑ Eating Disorder
- ❑ Learning Disability
- ❑ Personality Disorder
- ❑ Substance Related Disorder
- ❑ Other _____
- ❑ Autism Spectrum Disorder
- ❑ Bipolar Disorders
- ❑ Disruptive and Conduct Disorder
- ❑ Intellectual Disability
- ❑ Obsessive-Compulsive Disorder
- ❑ Schizophrenia Spectrum Disorder
- ❑ Trauma and Stressor Related Disorder

Have you received treatment or therapy for any of the above, either currently or in the past year? If YES check the box next to the item and provide details on the spaces below.

- ❑ Medication(s)
- ❑ Out Patient Counseling
- ❑ Day Treatment
- ❑ Residential Treatment
- ❑ Psychiatric Hospitalization

If you checked any of the above, please provide the following information for your therapist and/or prescribing physician:

Prescribing Physician Name: _____ Therapist Name: _____
Phone Number: _____ Phone Number: _____
Fax Number: _____ Fax Number: _____
Email: _____ Email: _____

Describe: _____

Describe: _____

PART V – SIGNATURE REQUIRED

All information will remain confidential except that information may be disclosed to a medical provider as needed for my (or my child's) care. Over the years, many participants with a variety of medical/psychological difficulties have successfully completed our programs, but we must be aware of these conditions. **Failure to disclose medical information could result in serious harm to you (or your child) and fellow participants. I understand that I may be in an area where communication, transportation, or evacuation is subject to delay.** I (or my child) will be attending an Outward Bound program and I give permission for any emergency anesthesia, operation, hospitalization or other treatment that may become necessary. I agree to be responsible for any and all charges associated with such treatment.

Applicant's Signature _____ **Date** _____
Parent's/Guardian's Signature _____ **Date** _____

(Required if applicant is under the age of 18 OR if applicant is a resident of Alabama and is under the age of 19 OR if applicant is a resident of Mississippi and is under the age of 21.)