OUTWARD BOUND

4 PAGE PARTICIPANT MEDICAL RECORD

RETURN

OFFICE USE ONLY

FOLLOW-UP

APPROVAL

PART I – GENERAL INFORMATION

PROGRAM/COURSE NUMBER: _____ START DATE: _____

Applicant

Title: ❑Dr. ❑Mr. ❑Mrs. ❑Miss ❑Other: _____

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: _____ Occupation: _____

Parent/Custodial Guardian 1 (if applicant is under the age of 21)

Title: ❑Dr. ❑Mr. ❑Mrs. ❑Miss ❑Other: _____

Name: _____

Relationship to Applicant: _____

Address: _____

City/State/Zip: _____

E-mail: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Occupation: _____

Parent/Custodial Guardian 2 (if applicant is under the age of 21)

Title: ❑Dr. ❑Mr. ❑Mrs. ❑Miss ❑Other: _____

Name: _____

Relationship to Applicant: _____

Address: _____

City/State/Zip: _____

E-mail: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Occupation: _____

Emergency Contact (other than parent/guardian if the applicant is under the age of 21)

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: _____

SIGNATURE REQUIRED Consent is hereby given for the applicant to attend an OUTWARD BOUND program and permission is given for any emergency anesthesia, operation, hospitalization or other treatment (whether for an emergency or not) which might become necessary. I agree to be responsible for any and all costs associated with such treatment, including the costs of evacuation, if any. All information will be kept confidential except that information may be disclosed to any medical or other provider as needed for my (or my child's) care. If Outward Bound arranges for treatment for me (or my child) by a medical provider, I authorize that medical provider to release information about me (or my child), and my (or my child's) condition and treatment to Outward Bound. Over the years, many students with a variety of medical and psychological difficulties have successfully completed our programs, but we must be aware of these conditions. **Failure to disclose such information could result in serious harm to you (or your child) and fellow students. I understand that I (or my child) may be in remote areas, several hours or days away from any medical facility or where communication, transportation, or evacuation is subject to delay.** If you (or your child) arrive at the program start with a pre-existing medical, behavioral or psychological condition which is not indicated on your medical form and you are subsequently unable to participate fully or are forced to leave the program because of that condition, you may be charged an evacuation fee and may not receive a refund of tuition.

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.)

PART II PARTICIPANT HISTORY: PAST AND PRESENT MEDICAL PROBLEMS

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

- **Specific symptoms that are occurring**
- **How often symptom/condition occurs**
- **How long symptom/condition lasts**
- **How you care for symptom/condition**
- **Date of last occurrence**
- **Any restrictions**

CONDITION	SYMPTOMS/RESTRICTIONS
❑ High Blood Pressure	
❑ Heart Disease	
❑ Heart Murmur	
❑ Irregular Heartbeat / Palpitations	
❑ Chest Pain / Pressure	
❑ Circulation Problems	
❑ Frostbite	
❑ Heatstroke	
❑ Frequent Dizziness / Fainting	
❑ History of Altitude Sickness	
❑ Severe Headaches / Migraines	
❑ Head injury with neurological impairment	
❑ Tuberculosis / Positive TB test	
❑ Asthma or COPD	
❑ Active or History of Hepatitis	
❑ Lyme Disease	
❑ Seizure Disorder / Epilepsy	
❑ Seizure within past 6 months	
❑ Bleeding / Blood Disorder	
❑ Sickle Cell Anemia	
❑ Sickle Cell Trait	
❑ Hypoglycemia (low blood sugar)	
❑ Diabetes	
❑ Cancer	
❑ Thyroid Problems	
❑ Gastro-intestinal Problems	
❑ Special Diet	
❑ Food Allergies	
❑ Kidney Problems	
❑ Urinary Tract Problems	
❑ Bedwetting	
❑ Orthopedic Problems	
❑ Broken Bones within past year	
❑ Hearing Impairment	
❑ Vision Impairment	
❑ Skin Problem	
❑ Motion Sickness	
❑ Sleep Walking	
❑ PMS/Menstrual Problems (severe)	
❑ Currently Pregnant	
❑ Medical Equipment/ Devices	
❑ Other	

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

Allergy List Below	Reaction List Below	Medication 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

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. Any changes to the above noted medications or dosages, please contact Outward Bound.

C. HOSPITALIZATIONS/EMERGENCIES Please list any hospital, psychiatric, or urgent care visits within the past 1 year.

Date of Visit/Admittance	Reason	Length of Stay

D. BLOOD PRESSURE

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.

E. IMMUNIZATIONS

We recommend that all of our participants have a current tetanus immunization (within 10 years).

F. PERSONAL HISTORY based on the past 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

Describe: _____

Describe: _____

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: _____

G. LIFESTYLE

Do any of the following apply to you? If YES check the box next to the item and provide details on the spaces below. **Include dates, amounts, reasons, etc.**

- ❑ Do you use alcohol? _____
- ❑ Do you use tobacco? _____
- ❑ Do you use recreational drugs or marijuana? _____
- ❑ Do you have a history or current problem with substance abuse or dependency? _____
- ❑ Have you been suspended or expelled from school in the past year? _____
- ❑ Have you been on probation or had any involvement with the justice system? _____

H. 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

I. SWIMMING ABILITY (CHECK ONE)

❑ Non-Swimmer ❑ Weak Swimmer ❑ Moderate Swimmer ❑ Strong Swimmer