OUTWARD BOUND

1 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.

PART I - GENERAL INFORMATION

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

Applicant

Name: _____ Sex identified as: ❑ Male ❑ Female ❑ _____

Address: _____ Apt #: _____ Age at Program Start: _____ Date of Birth: _____

City/State/Zip: _____ Height: _____ feet _____ inches Weight: _____ lbs.

Home Phone: _____ Do you speak English? ❑ Yes ❑ No

Cell Phone: _____ If not, what language is spoken at home? _____

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

Name: _____ Email: _____

Preferred Telephone #1: _____ Preferred Telephone #2: _____

Emergency Contact (not a parent or guardian)

Name: _____ Relationship to Applicant: _____

Preferred Telephone #1: _____ Preferred Telephone #2: _____

PART II – MEDICAL INFORMATION

A. HEALTH HISTORY 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
❑ Diabetes
❑ Seizure within the past year
❑ Concussion or other significant injury in the past year
❑ Other _____
❑ Blood Disorder, such as Sickle Cell or Hemophilia
❑ Currently Pregnant
❑ Bed Wetting
❑ Special Diet

Details or Restrictions: _____

B. ALLERGIES List any allergies you have, including allergies to medicines, foods, and insect/bee stings.

Allergy to: _____ Reaction: _____ Medication used: _____

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C. MEDICATIONS Include psychiatric medication, over-the-counter medication, inhalers, and herbal supplements.

Medication: _____ Taken For: _____ Start Date: _____

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D. PERSONAL HISTORY Check any of the following that apply.

❑ Learning Difference ❑ ADHD ❑ Anxiety ❑ Suicidal thoughts ❑ Violent Behavior ❑ Eating Disorder

PART III – 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 students 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 (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.)