OUTWARD BOUND

2 PAGE ADULT MEDICAL RECORD

RETURN

OFFICE USE ONLY

FOLLOW-UP
APPROVAL

INSTRUCTIONS Please fully complete and return this form as soon as possible in order to allow us adequate time for review and possible follow-up questions. We will determine the status of your participation after review of this form. We may require further evaluation by a physician in order for you to fully participate. If you choose to not proceed with the recommended follow-up, you may have the option of limited participation (based on our assessment of your medical constraints). Please return the form, regardless of what choice you make. Please write legibly in blue or black ink.

NOTE: Most of our programs are structured to accommodate various levels of participation. Regardless of your participation status, you will be able to be fully interactive with your group during most of the program activities. **If you arrive at the program without a pre-reviewed medical record, your status will be as OBSERVER, only.**

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: _____ Occupation: _____

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.

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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.

- ❑ Seizure within the past 6 months
- ❑ Hospitalization/Emergency Room/Urgent Care visit within past year
- ❑ History heart attack, by pass/angioplasty/angina
- ❑ Other cardiac conditions, e.g., heart murmur or other rhythm abnormality
- ❑ Current orthopedic problems (neck/back/knee/shoulder)
- ❑ Medical Device, e.g., hearing aid/prosthetic device
- ❑ Currently pregnant
- ❑ Special Diet
- ❑ Other medical issues/illnesses/symptoms/ requirements

Describe: _____

Describe: _____

PART IV – CARDIOVASCULAR RISK FACTORS

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

- ❑ Diagnosed high blood pressure, even if being controlled with medication (150/90 or higher in either case)
- ❑ Smoked tobacco regularly within the past year
- ❑ Diabetes
- ❑ Abnormally high cholesterol level or on a diet or medication for a lipid abnormality
- ❑ Family history (parent/sibling) of heart attack, coronary artery by-pass/angioplasty, or sudden, unexplained death before age 55
- ❑ Unexplained chest pain/pressure, shortness of breath, heart palpitations, sweats/exertional dizziness/faint spells

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 V – SIGNATURE REQUIRED

All information will remain confidential except that information may be disclosed to a medical provider as needed for my 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 and your fellow participants. I understand that I may be in an area where communication, transportation, or evacuation is subject to delay.** I 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** _____

(Applicant must be over the age of 18 OR if applicant is a resident of Alabama must be over the age of 19 OR if the applicant is a resident of Mississippi must be over the age of 21)

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