Instructor Notes

Office Use Only | Follow-up/Approval

Participant Confidential Medical Record

Pages 1 - 4 to be completed by the applicant or parent/guardian (if applicant is under the age of 18) and provided to the examining MD, DO, CRNP, or PA.
Please write legibly in blue or black ink.

PART I General Information

Program/Course ____________ **Starting Date** _______

Applicant

Name ______________________________________
Gender ☐ Male ☐ Female
Age at Program Start _______ DOB _____/_____/_____
Height __________ft. ___________inches
Weight _________lbs.
Occupation ______________________________________

Address ______________________________________
____
City/State/Zip ______________________________________
Daytime Telephone ______________________________________
Evening Telephone ______________________________________
FAX ______________________ Cell ________________
email ______________________________________

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

Name ______________________________________
Relationship ______________________________________
Address ______________________________________
City/State/Zip ______________________________________
Occupation ______________________________________
Home Telephone ______________________________________
Work Phone __________________ Cell ________________
FAX #/email ______________________________________

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

Name ______________________________________
Relationship ______________________________________
Address ______________________________________
City/State/Zip ______________________________________
Occupation ______________________________________
Home Telephone ______________________________________
Work Phone __________________ Cell ________________
FAX #/email ______________________________________

Emergency Contact (not parent/guardian)

Name ______________________________________
Relationship ______________________________________
Daytime Telephone # ______________________________________
Evening Telephone # ______________________________________
Cell Phone # ______________________________________

Family Physician

Name ______________________________________
Telephone # ______________________________________
FAX # ______________________________________

Do you speak/understand English?
☐ Yes ☐ No

Ethnic Background (Optional)

☐ Asian	☐ Caucasian (Non-Hispanic)	☐ American Indian/Alaskan Native
☐ Multi-Ethnic	☐ Native Hawaiian or Pacific Island	☐ Do Not Know Ethnicity
☐ Hispanic or Latino	☐ African American	☐ Other ______________________

Insurance Information *Each participant is responsible for any medical expenses and should be covered by his/her own illness and accident insurance*

DO YOU HAVE INSURANCE? ☐ Yes ☐ No If Yes, Group #_______________ Policy #_________________________
IF YOU HAVE INSURANCE, PLEASE ATTACH A PHOTOCOPY OF BOTH THE FRONT AND BACK OF YOUR INSURANCE CARD.

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 or Nebraska 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

A. Conditions and Symptoms *(Please FILL in EVERY blank!)*

#	Condition	Y	N	#	Condition	Y	N	#	Condition	Y	N
1	High Blood Pressure			24	Frostbite			47	Ankle Problem		
2	Heart Disease			25	Circulation Problems			48	Leg/Hip Problem		
3	Heart Murmur			26	Bedwetting			49	Foot Problem		
4	Irregular Heartbeat			27	Headaches			50	Currently Pregnant		
5	Family history of heart attack			28	Head injury with neurological impairment			51	Medical Equipment/ Devices		
6	Tuberculosis			29	Stomach Ulcers			52	Learning Disability		
7	Recent Exposure to Active TB			30	Intestinal Problems			53	Special Diet		
8	Positive TB test			31	Heatstroke			54	Unexpected Weight Loss		
9	Active or History of Hepatitis			32	Bladder Infection			55	History of Altitude Sickness		
10	Lyme Disease			33	Difficulty Urinating			**Do you currently or regularly have any of the following symptoms?**			
11	Seizure Disorder/Epilepsy			34	Kidney Problems						
12	Seizure w/in past year			35	Thyroid Problems			56	Chest Pain/Pressure		
13	Bleeding / Blood Disorder			36	Endocrine Problems			57	Heart Palpitations		
14	Sickle Cell Anemia or Sickle Cell Trait			37	Hearing Impairment			58	Frequent Shortness of Breath		
15	Chronic Cough			38	Vision Impairment			59	Unexplained Sweating		
16	Recurrent Lung Infections			39	Motion Sickness			60	Frequent Dizziness		
17	Asthma			40	Sleep Walking			61	Frequent Fainting		
18	Diabetes			41	Broken Bones			62	Heartburn		
19	Hypoglycemia (low blood sugar)			42	Neck Problem			63	Muscle Cramps		
20	Anorexia Nervosa			43	Back Problem			64	Intolerance to Warm **or**		
21	Bulimia			44	Elbow/Wrist/Hand Problem			65	Cold Temperatures		
22	Cancer			45	Shoulder Problem			66	PMS/Menstrual Problems		
23	Skin Problem			46	Knee Problem			67	Other		

If you have answered "yes" to any of the above items, please explain below. Include the following:

- **Specific symptoms that are occurring**
- **How long symptom/condition lasts**
- **Date of last occurrence**
- **How often symptom/condition occurs**
- **How you care for symptom/condition**
- **How symptom/condition restricts your activity in any way, including your ability to run, lift, and climb**

Item #	Detailed Description (including restrictions, if any)

B. Allergies - Including allergies to medicines, foods, insect bites/stings

NONE ☐ **OR...**

Allergy List Below	Reaction	Medication Required (if any)

C. Medications You Are Currently Taking

If psychiatric medication, please list any taken within the past 2 months

NONE ☐ **OR... list any you are using including psychiatric, over-the-counter, inhalers, herbal supplements**

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

D. Immunization

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

E. Hospitalizations/Emergencies/Urgent Care

NONE ☐ **OR... please list any hospital, emergency department, or urgent care visits within the past 2 years**

Date of Visit/Admittance	Reason	Length of Stay

F. Blood Pressure - Must be taken within 6 months of program start

Blood Pressure ____________/____________ If BP s over 150/90, please take a second reading:

Date Taken ______________________________ Second Reading _______/________ Date Taken__________________

Blood pressure may be taken with apparatus at a local department or drug store.

G. Personal History - Based upon past one to two years

#	Counseling History (Based upon past two years) Date of Last Session ____________________
1	Have you been diagnosed or treated for any of the following within the past two years? Y☐ N☐ Attention Deficit Disorder (ADD) Y☐ N☐ Adjustment Disorder Y☐ N☐ Anxiety Disorder Y☐ N☐ Disruptive Behavior Disorder Y☐ N☐ Eating Disorder Y☐ N☐ Impulse Control Disorder Y☐ N☐ Learning Disorder Y☐ N☐ Mental Retardation Y☐ N☐ Mood Disorder Y☐ N☐ Personality Disorder Y☐ N☐ Pervasive Developmental Disorder Y☐ N☐ Schizophrenia Y☐ N☐ Substance Related Disorder Y☐ N☐ Other ____________________
2	Have you received any of the following treatment or therapy for any of the above conditions? Y☐ N☐ Medication(s) Y☐ N☐ Out Patient Counseling Y☐ N☐ Day Treatment Y☐ N☐ Residential Treatment Y☐ N☐ Psychiatric Hospitalization
3	Are you currently (or within the past 1 year) taking medication(s) for any mental health issue? Yes ☐ No ☐
4	Have you experienced any of the following significant events within the past year? If yes, please explain Y☐ N☐ Serious illness ____________________ Y☐ N☐ Serious accident/injury ____________________ Y☐ N☐ Self harm ____________________ Y☐ N☐ Expulsion ____________________ Y☐ N☐ Incarceration ____________________ Y☐ N☐ Death of Family/Friend ____________________
5	Please arrange for a release of information with your therapist and/or prescribing physician so we may contact them for further information as part of this screening process. Have you done so? YES ☐ NO ☐
6	Please provide the name and telephone & fax #s of your therapist and/or physician: Therapist ____________________ Tel # ____________________ Fax # ____________________ Physician ____________________ Tel # ____________________ Fax # ____________________

H. Lifestyle

#	Issue	Yes	No	Further Information
1	Do you use alcohol?			How much? How often?
2	Do you use tobacco?			How much? How often?
3	Do you use recreational drugs?			Which one(s)? How often?
4	Have you been on probation or had any involvement with the Justice System?			Date(s): Reason:

I. Current Exercise Activity - It is important for us to be aware of your fitness level

Please list the activities you engage in daily or weekly that indicate your current fitness level. Be sure to include activities such as walking a pet, mowing a lawn, playing basketball, School PE, or skateboarding.

NONE ☐ **No regular physical activity**

Activity	Frequency	Approximate Time/Distance	Leisurely	Moderately	Intensely

Note: You will be expected to engage in rigorous physical activity during your Outward Bound experience. It is vital that you start (or continue) a conditioning regimen in preparation for the program!

J. Swimming Ability (Check One)

☐ Non-Swimmer
☐ Weak Swimmer
☐ Moderate Swimmer
☐ Strong Swimmer
☐ Current Lifesaving Certificate

PART III Physician's Examination Section

To the Physician, Licensed Nurse Practitioner, or Physician's Assistant:

You are being asked to consult on this applicant because we want them to have a safe and healthy experience. These courses contain elements of significant physical stress requiring more strength and endurance than most individuals ordinarily encounter. Your patient may be involved in activities such as:

- **Backpacking w/50-60 lb. pack, hours at a time, over rough terrain**
- **Portaging 70 lb. canoe, up to several miles, across rough terrain**
- **Rock climbing or a ropes course—extreme heights**
- **Remote wilderness setting**
- **Immersion in cold water**
- **Running on uneven ground**
- **High altitude hiking/backpacking**

We have found that people who are in overall good health with average physical ability can successfully complete the program. However, because the programs often take the participants to remote areas where quick access to medical facilities may be delayed for 8 hours or longer, prevention of serious health hazards becomes paramount. We appreciate your help—your assessment of this patient and our knowledge of the course elements will allow us to make an accurate medical screening decision. Thank you!

A. Vital Signs/Statistics

Information must be based upon examination done within one year of course start date

Patient's Name ______________________________ **Blood Pressure** ________/________

Height ____________ **Weight** ____________ **BMI** __________ **IF BP is over 150/90, please repeat:**

Please indicate if patient is over or underweight: **Second Reading** _______/_______

Overweight by _________ **lbs. Underweight by** _________ **lbs.**

Pulse Irregularities ☐ **No** ☐ **Yes**

If yes, please describe symptoms and indicate clinical significance: ______________________

B. Physician's Examination

Information must be based upon examination done within one year of course start date

√ if normal		Describe if abnormal	√ if normal		Describe if abnormal
Eyes/Ears			Abdomen		
Nose			Hernia		
Throat/Mouth			Back		
Neck			CNS		
Thyroid			Lymph Nodes		
Thorax/Lungs			Skin		
Heart			Extremities		
Heart Murmur			Shoulders		
If Murmur -- Functional			Knees		
			Ankles/Feet		
Peripheral Vsls.			Other		

Condition		Is Condition Controlled/Stable?	Condition		Is Condition Controlled/Stable?
Asthma			Seizures		
Hypertension			Allergies-food		
High Cholesterol			Allergies-other		
Diabetes			Other		

C. Summary of Active Medical Problems and/or Restrictions

NONE ☐ **or list below**

____

____

____

____

D. Pre-Acceptance Cardiovascular Testing

This program may include a high ropes course and/or rock climbing, or other similar activities. Because these activities can cause both physical stress and anxiety, cardiovascular response may produce an unusually high pulse rate. If this patient has a sedentary lifestyle, is significantly overweight, is over 40, and/or has any of the following cardiovascular risk factors, we may suggest (and in some cases, require) that further cardiovascular testing be done prior to participation in the program.

- Diagnosed high blood pressure, even if being controlled with medication **(150/90 or higher in either case)**
- Smoker (smoked regularly within the past year)
- Diabetes
- Known 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**
- Current cardiovascular disease or History of prior heart disease
- Unexplained chest pain/pressure, shortness of breath, palpitations, sweats or exertional dizziness or faint spells

> ➢ Do you think an exercise stress test may help assess this applicant's risk of a serious cardiac event during the stresses described above for this course? ☐ **No** ☐ **Yes**
>
> ➢ Has this patient had an exercise stress test within the past year? ☐ **No** ☐ **Yes**
>
> ➢ Please forward a copy of the test summary**:** ☐ **Enclosed** ☐ **Will FAX**
>
> **Participation in this program will depend upon interpretation of the test.**

E. Physician Recommended Referrals

Do you feel further examination or specialty referral is indicated for this patient prior to participation in this wilderness program? ☐ **No** ☐ **Yes** Please explain: ____

Consulting Opinion: ☐ **Enclosed** ☐ **Will FAX**

F. Immunization

> **We recommend that all of our participants have a current tetanus immunization (w/in 10 years)**

G. Known Medications If any please list. Indicate if NONE.

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

H. Additional Comments: ____

____

____

I. Physician's Signature

How long have you known the applicant? ____

Please print physician's name: ____

Physician's Signature ____ **Date of Exam** _____/______/______

Must be within 1 year of start date

Telephone (_____)_______________ FAX (_____)_______________ Email ______________________________