North Carolina
Outward Bound

FINS PROGRAM OVERVIEW

CINS/FINS Program
Children and Families in Need of Services

The Population
Our students are troubled adolescents,
13-17 years old, who are typically referred by youth-serving agencies and schools. These youths have low self-esteem, are unmotivated, and are experiencing more than the usual adolescent problems, such as low motivation, poor decision making skills, susceptibility to peer pressure, repeated failures, impulsive behavior, refusal to take responsibility for their actions etc.

The Program
The North Carolina Outward Bound School (NCOBS) operates highly structured 20 day educational expeditionary courses for troubled youth. The first phase of each course is a demanding 20-day canoeing expedition conducted on the river systems of Central Florida. Along with their instructors, students paddle 10-
15 miles each day before establishing camp at remote riverside sites. They cook their own meals, sleep in tents, and as a group deal with behavioral problems when they occur. Following this wilderness phase, a follow-up reinforcement component begins with program staff working with students and their families in their homes, schools, and communities, to insure a logical transference of skills from the wilderness back to home.

North Carolina Outward Bound: Finding Personal Limits
The NCOBS program exposes adolescents to new and demanding situations while enhancing their abilities to meet demands and to act positively beyond their perceived personal limits. From the beginning, students are challenged mentally and physically to do things they never thought possible.

Confidence and self-esteem develop as students learn the skills of wilderness living, such as canoeing, camp craft, first aid, and navigation. Students learn that, in order for the expedition to proceed, cooperation among participants is needed; group decision-making and problem-solving skills are learned and responsible behaviors are fostered.

What is required of Parents?
Parental support and interaction play a crucial role in the success of the program. Through parent education meetings, family behavioral contracts and frequent family sessions, both parents and students develop more effective communications and coping skills.

Parents are required to:
- Provide transportation to and from the program site.
- Attend one meeting during the 20-day expeditionary phase.
- Write 3 letters to their child while on course.
- Participate in Mediation Session
- Participate in home visits & Family Gatherings during the reinforcement phase.

Staff
NCOBS instructors are skilled at safely leading groups of troubled adolescents on wilderness expeditions. Instructors counsel the individual student as issues arise and provide expertise in problem solving.

Course Referral Information
NCOBS has been contracted by the State of Florida, Department of Juvenile Justice to provide services to adolescents and their families in the following counties: Brevard, Orange, Osceola, Seminole, Volusia and Flagler. A family interview and physical is required prior to a student's acceptance into the program. Equipment is provided, and students need only bring an open mind and willingness to participate.

For Further Information
Contact your local DJJ office or the North Carolina Outward Bound School at 3500 Sunset Ave, Mims FL 32754 (321) 268-5666

Funding for this program is solely from the State of Florida, Department of Juvenile Justice.

North Carolina Outward Bound

FINS Application Form

(Please Print Clearly)

Child's Legal Name: _____
Last First Middle

Address: _____
Street City County Zip

D.O.B ___/___/___AGE:_____RACE:_____SEX:_____HEIGHT:_____WEIGHT:_____EYES:_____HAIR:_____

Child's Social Security Number:_____/_____/_____ State Born :_____

REFERRING COUNSELOR: I have interviewed (by phone or in person) the parent(s) and the child listed below and have determined that referral to the Outward Bound FINS Program is appropriate

Has Client Ever Applied previously?
Yes or No (*please circle)*

_____ / / _____
Printed Name Signature Date

Referring Agency Name:_____ Phone# (____) _____

Agency Address: _____ **Email Address:** _____

Comments: _____

PARENT/GUARDIAN LIVING WITH THE CHILD:

Mother/Step Mother Name: _____ Relationship: _____

Home Phone# (____) _____ Business:(____) _____

Other Contact Number (Cell, Etc.) _____

Father/Step Father Name:_____ Relationship: _____

Home Phone# (____) _____ Business:(____) _____

Other Contact Number (Cell, Etc.) _____

E-mail address _____

Other Adults Living at Home: _____ Relationship: _____

SCHOOL NAME:_____ Grade in Now:_____ School Fax # _____

Address: _____
Street City Zip (Please fill out completely)

Contact:_____ **Does your child receive a McKay Scholarship?**
Yes or No (*please circle)*

REASON FOR REFERRAL:

Please be thorough and accurate in filling out this application. Explain what the history is at home and school etc.

Home: _____

School: _____

Prior History: (Indicate prior involvement with DJJ or CINS/FINS residential placement) _____

Have any other placements been discussed? Yes or No If yes, what?

Has the School System ever diagnosed your child as Severely Emotionally Disabled or Emotionally Mentally Handicapped? Yes or No If Yes, When?

Child and or family currently involved in any type of therapy? Yes or No If yes, with whom?

Name Agency

Address City State Zip Phone#

Does the child have a history of violent behavior? Yes or No
At Home? (Please explain) _____

At School? (Please explain) _____

Is the child currently on community control or probation? Yes or No _____
If yes, for what and how long? _____

Does child have criminal charges pending? Yes or No If yes, Please explain _____

Has any of the childs immediate family been convicted of a crime? Yes or No If yes, Please explain

Does the child have any physical, mental or emotional limitations that might prevent full participation in this program?
Yes or No If yes, Please specify: _____

Is child presently (or within the last six months) on psychotropic drugs for any reason? Yes or No
If yes please specify the following:

Drug Name Dosage Amount taken per day How long on Med

Drug Name Dosage Amount taken per day How long on Med

Prescribing Doctor's Name _____ Agency Name _____

Fax # Phone#

Is your child asthmatic? Yes or No If yes, do they use an inhaler? Yes or No How often: _____
What induces your childs asthma? _____

Is the child currently on any other medication? Yes or No If yes, what and why?

I hereby authorize North Carolina Outward Bound to have access to any information the signing referring agency may have regarding my child, _____

Name of Child

I agree that, in order to help facilitate positive behavioral changes in my child, I will attend at least Four meetings while my child is participating in the NC Outward Bound Program. My Spouse and I will also participate with our child for the final graduation at the end of the course. I hereby authorize any physician, hospital, or dentist to provide an examination and or written treatment as, in their opinion, is necessary for the above named child.
I further authorize any physician, dentist, hospital or clinic to furnish the Department of Juvenile Justice, or its authorized agent, any verbal or written information pertaining to the present or past state of health and medical treatment given to my child. I/We also agree to be financially responsible for the care of any sickness, dental care or injury to my child while participation in the NC Outward Bound School CINS/FINS Program and hereby give permission for the hospital/ Physician to file a direct claim to the insurance company or Medicaid on my behalf. I authorize that a photocopy of this form may be considered as valid as the original

_____

Parent/Guardian Signature Printed Name Date

Note: Before mailing, be sure to answer ALL QUESTIONS and be sure that the form is signed by Parent/Guardian.

Mail To: North Carolina Outward Bound School
C/O Intake Coordinator
3500 Sunset Ave
Mims FL 32754

Phone 321-268-5666 or 800-673-3096
Fax 888-240-3512

Email: dcaldwell@ncobs.org

NC Outward Bound is a non profit, tax-exempt educational organization, and admits students without regard to sex or race to all the rights, privileges, programs, and activities generally accorded or made available to students; and does not discriminate on the basis of sex or race in admissions policies financial aid, and loan, programs, or other school administered programs.

RETURN

OUTWARD BOUND

Instructor Notes

Office Use Only

Follow-up/Approval

Participant Confidential Medical Record

This form may be filled in **on-line** and signed with a digital signature option. Or you may print out this form and fill it in using **blue or black ink**.

PART I General Information

Program/Course _____ Starting Date _____

Applicant

Name _____

Address _____

City/State/Zip _____

Home Telephone

Cell _____

Email _____

Gender ☐ Male ☐ Female

Age at Program Start _____ DOB ____/____/____

Height _____ ft. _____ inches

Weight _____ lbs.

BLOOD PRESSURE - Taken within 6 months of course start

Blood Pressure _____/_____

Date Taken _____

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

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

Name _____ Email

Relationship _____ Occupation

Address _____ City/State/Zip _____

Preferred Telephone #1 _____ Preferred Telephone #2 _____

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

Name _____ Email

Relationship _____ Occupation

Address _____ City/State/Zip _____

Preferred Telephone #1 _____ Preferred Telephone #2 _____

Emergency Contact (not parent/guardian)

Name _____ Relationship _____

Preferred Telephone #1 _____ Preferred Telephone #2 _____

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 _____

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 18 years of age OR if applicant is from Alabama or Nebraska and under 19 years of age 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. **If you answer "yes" to any of the 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**
- **Any restrictions**

#	Condition	Y	N	Detailed Description (including restrictions, if any)
1	High Blood Pressure	☐	☐	
2	Heart Disease	☐	☐	
3	Heart Murmur	☐	☐	
4	Irregular Heartbeat / Palpitations	☐	☐	
5	Family history of heart attack	☐	☐	
6	Chest Pain / Pressure	☐	☐	
7	Circulation Problems	☐	☐	
8	Frostbite	☐	☐	
9	Heatstroke	☐	☐	
10	Frequent Dizziness / Fainting	☐	☐	
11	History of Altitude Sickness	☐	☐	
12	Headaches / Migraines	☐	☐	
13	Head injury with neurological impairment	☐	☐	
14	Tuberculosis / Positive TB test	☐	☐	
15	Asthma or COPD	☐	☐	
16	Active or History of Hepatitis	☐	☐	
17	Lyme Disease	☐	☐	
18	Seizure Disorder / Epilepsy	☐	☐	
19	Seizure within past 6 months	☐	☐	
20	Bleeding / Blood Disorder	☐	☐	
21	Sickle Cell Anemia	☐	☐	
22	Sickle Cell Trait	☐	☐	
23	Hypoglycemia (low blood sugar)	☐	☐	
24	Diabetes	☐	☐	
25	Cancer	☐	☐	
26	Thyroid Problems	☐	☐	
27	Gastro-intestinal Problems	☐	☐	
28	Special Diet	☐	☐	
29	Food Allergies	☐	☐	
30	Kidney Problems	☐	☐	
31	Urinary Tract Problems	☐	☐	
32	Bedwetting	☐	☐	
33	Orthopedic Problems	☐	☐	
34	Broken Bones within past year	☐	☐	
35	Hearing Impairment	☐	☐	
36	Vision Impairment	☐	☐	
37	Skin Problem	☐	☐	
38	Motion Sickness	☐	☐	
39	Sleep Walking	☐	☐	
40	PMS/Menstrual Problems (severe)	☐	☐	
41	Currently Pregnant	☐	☐	
42	Medical Equipment/ Devices	☐	☐	
43	Other	☐	☐	
44	Other	☐	☐	

B. Allergies - **Including allergies to medicine, foods, insect bites/stings, environmental, etc.**

☐ **NONE**

(Or list to right)

Allergy List Below	Reaction List Below	Medication Required (if any)

C. 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.

☐ **NONE**

(Or list to right)

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. Hospitalizations/Emergencies/Urgent Care

Please list any hospital, psychiatric, or urgent care visits within the past 1 year

☐ **NONE**

(Or list to right)

Date of Visit/Admittance	Reason	Length of Stay

E. Immunization

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

Personal History - Based upon past 1 year

#1 Have you been diagnosed or treated for any of the following disorders currently or within the past year?

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 ☐ Developmentally Disabled
Y ☐ N ☐ Mood Disorder
Y ☐ N ☐ Personality Disorder
Y ☐ N ☐ Pervasive Developmental Disorder
Y ☐ N ☐ Substance Related Disorder
Y ☐ N ☐ Schizophrenia
Y ☐ N ☐ Other _____

#2 Have you received treatment or therapy for any of the following, either currently or in the past year?

Y ☐ N ☐ Medication(s)
Y ☐ N ☐ Out Patient Counseling
Y ☐ N ☐ Day Treatment
Y ☐ N ☐ Psychiatric Hospitalization
Y ☐ N ☐ Residential Treatment

#3 Have you experienced any of the following significant events within the past year? If yes, please explain

Y ☐ N ☐ Serious illness _____ Y ☐ N ☐ Expulsion
Y ☐ N ☐ Serious accident/injury _____ Y ☐ N ☐ Incarceration
Y ☐ N ☐ Self harm _____ Y ☐ N ☐ Death of Family/Friend _____

#4 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 ☐

#5 Please provide the name and telephone & fax #s of your therapist and/or prescribing physician:

Therapist _____ Telephone # _____
Fax # _____ Email _____

Prescribing Physician _____ Telephone # _____
Fax # _____ Email _____

F. 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:
5	Do you have a history or current problem with substance abuse/dependency?			How long?

G. 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 all activities.

☐ **NONE**

(Or list to right)

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

OUTWARD BOUND

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**

_____

_____

_____

_____

OUTWARD BOUND

PART III Physician's Examination Section

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** _____