



APPLICANT BOOKLET – ADULT

This form does not require a physician's exam

Welcome to Outward Bound!

All participants are required to complete our Medical Record booklet. The information you provide informs us of your physical and emotional ability to attend course and helps determine if an Outward Bound course is appropriate for you at this time.

Take time to answer questions completely. Every item in the Medical Record booklet must be completed. Mark a section "N/A" if it is not applicable to you. Any item or section not completed will require follow-up. Failure to fully complete required forms will delay your application. (Keep a copy of this booklet for your records.)

You must notify the Student Services Department should any medical, psychological, behavioral or legal situations occur after the application and medical review process have been completed. Certain situations may affect the applicant's course status.

DIVERSITY AND NON-DISCRIMINATION STATEMENT

NCOBS prohibits discrimination against any student or applicant because of race, color, religion, sex, gender, ethnic or national origin, sexual orientation, qualified individuals with disabilities on the basis of disability, or any other category which may be protected by applicable state or federal law. NCOBS also promotes respect for all people and will not tolerate harassment based on any of these characteristics nor on differences based on gender identity or expression.

MEDICATIONS

Please see the information on Medications under the Clothing & Gear List Tab on your course page.

ADDITIONAL FORMS

Based on the answers you have provided in this booklet, we may require that you complete and submit additional forms.

HEALTH INSURANCE

During your course, you should be covered by your own or your family's health and/or accident insurance. Please provide your policy number, company name and address as well as the policy holder's name. Also required is a copy of the front and back of your health insurance card. Bills for medical treatment will be the responsibility of your insurance company.

If you are not covered by health and/or accident insurance, you or your family are responsible for these costs. If you do not have health insurance, we suggest you consider purchasing a short-term health insurance plan.

NUTRITION

Please see the information on Nutrition under the General Info Tab on your course page.

QUESTIONS

If you have questions regarding medical information, contact our Medical Screener at 800-709-6098 or email medical@ncobs.org.

Other non-medical questions should be directed to your Student Services Representative by calling 1-800-924-5497 or by emailing studentservices@ncobs.org.



RETURN

FOLLOW-UP

APPROVAL

4 PAGE PARTICIPANT MEDICAL RECORD

OFFICE USE ONLY

PART I – GENERAL INFORMATION

PROGRAM/COURSE NUMBER _____ START DATE _____

APPLICANT

Name: _____ Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other _____
Address: _____ Age at Program Start: _____ DOB: _____
City/State/Zip: _____ Height: _____ ft. _____ in. Weight: _____ lbs.
Home Phone: _____ Sex: ☐ Male ☐ Female ☐ Intersex
Cell Phone: _____ Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Transgender
E-mail: _____ Occupation: _____

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

Name: _____
Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other _____
Relationship to Applicant: _____
Address: _____
City/State/Zip: _____
E-mail: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Occupation: _____

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

Name: _____
Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other _____
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 21)

Name: _____ Relationship to Applicant: _____
Home Phone: _____ Cell: _____
Email Address: _____ Work Phone: _____

Ethnicity (optional)

- | | | |
|---------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Asian | <input type="checkbox"/> Caucasian (Non-Hispanic) | <input type="checkbox"/> American Indian/Alaskan Native |
| <input type="checkbox"/> Multi-Ethnic | <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> African American | <input type="checkbox"/> 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 preexisting 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 APPLICANT MEDICAL HISTORY: PAST AND PRESENT

A. MEDICAL CONDITIONS

Do any of the following apply to you? If YES check the box next to the item and provide detail in the spaces 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	SYMPTOMS/RESTRICTIONS
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Heart Murmur	
<input type="checkbox"/> Irregular Heartbeat/Palpitations	
<input type="checkbox"/> Chest Pain/Pressure	
<input type="checkbox"/> Circulation Problems	
<input type="checkbox"/> Frostbite	
<input type="checkbox"/> Heatstroke	
<input type="checkbox"/> Frequent Dizziness/Fainting	
<input type="checkbox"/> History of Altitude Sickness	
<input type="checkbox"/> Severe Headaches/Migraines	
<input type="checkbox"/> Head Injury w/Neurological Impairment	
<input type="checkbox"/> Tuberculosis/Positive TB test	
<input type="checkbox"/> Asthma or COPD	
<input type="checkbox"/> Active or History of Hepatitis	
<input type="checkbox"/> Lyme Disease	
<input type="checkbox"/> Seizure Disorder/Epilepsy	
<input type="checkbox"/> Seizure within past 6 months	
<input type="checkbox"/> Bleeding/Blood Disorder	
<input type="checkbox"/> Sickle Cell Anemia	
<input type="checkbox"/> Sickle Cell Trait	
<input type="checkbox"/> Hypoglycemia (low blood sugar)	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Cancer	
<input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> Gastro-intestinal Problems	
<input type="checkbox"/> Special Diet	
<input type="checkbox"/> Food Allergies	
<input type="checkbox"/> Kidney Problems	
<input type="checkbox"/> Urinary Tract Problems	
<input type="checkbox"/> Bedwetting	
<input type="checkbox"/> Orthopedic Problems	
<input type="checkbox"/> Broken Bones within past year	
<input type="checkbox"/> Hearing Impairment	
<input type="checkbox"/> Vision Impairment	
<input type="checkbox"/> Skin Problem	
<input type="checkbox"/> Motion Sickness	
<input type="checkbox"/> Sleep Walking	
<input type="checkbox"/> PMS/Menstrual Problems (severe)	
<input type="checkbox"/> Currently Pregnant	
<input type="checkbox"/> Medical Equipment/Devices	
<input type="checkbox"/> Other	

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

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.

Medication List Below	Taken For Symptom/Condition	Dosage Size/Frequency	Date Started	Current Side Effects	Expiration Date

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 prior to course must be shared with Outward Bound as soon as possible.*

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

Date of Visit/Admittance	Reason	Length of Stay

E. **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.

F. **IMMUNIZATIONS**

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

PART III APPLICANT PSYCHIATRIC AND MENTAL HEALTH HISTORY

G. PSYCHIATRIC AND MENTAL HEALTH CONDITIONS Within 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.

- | | |
|-----------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Autism Spectrum Disorder |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Depressive Disorder | <input type="checkbox"/> Disruptive and Conduct Disorder |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Intellectual Disability |
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Obsessive Compulsive Disorder |
| <input type="checkbox"/> Personality Disorder | <input type="checkbox"/> Schizophrenia Spectrum Disorder |
| <input type="checkbox"/> Substance Related Disorder | <input type="checkbox"/> Trauma and Stressor Related Disorder |
| <input type="checkbox"/> Other: _____ | |

Describe: _____

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 detail on the spaces below?

- | | |
|-------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Medication(s) | <input type="checkbox"/> Residential Treatment |
| <input type="checkbox"/> Out Patient Counseling | <input type="checkbox"/> Psychiatric Hospitalization |
| <input type="checkbox"/> Day Treatment | |

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: _____
E-mail: _____	E-mail: _____

PART IV APPLICANT PERSONAL HISTORY

H. 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.

- | | |
|-------------------------------------------------------------------------------------------------------|-------|
| <input type="checkbox"/> Do you use alcohol? | _____ |
| <input type="checkbox"/> Do you use tobacco? | _____ |
| <input type="checkbox"/> Do you use recreational drugs or marijuana? | _____ |
| <input type="checkbox"/> Do you have a history or current problem with substance abuse or dependency? | _____ |
| <input type="checkbox"/> Have you been suspended or expelled from school in the past year? | _____ |
| <input type="checkbox"/> Have you been on probation or had any involvement with the justice system? | _____ |

I. CURRENT PHYSICAL 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

J. SWIMMING ABILITY (CHECK ONE)

- ☐ Non-Swimmer ☐ Weak Swimmer ☐ Moderate Swimmer ☐ Strong Swimmer

APPLICANT QUESTIONNAIRE

1. What are you most looking forward to on your Outward Bound course?

2. What goals are you setting for yourself while on course?

3. How can your instructors and/or crew members contribute to your experience?
How can you contribute to their experience?

4. Do you have any prior outdoor experience? ☐ Yes ☐ No
If "Yes," explain.

5. What concerns, if any, do you have about your Outward Bound course?

BEFORE you sign, please confirm that you have responded to all questions. DOUBLE CHECK page 1 to confirm that you recorded date of birth (DOB), height, weight and blood pressure. This is REQUIRED information.

Applicant Signature: _____

INSURANCE INFORMATION

- 1. IF YOU ARE MAILING YOUR FORMS, STAPLE OR TAPE A COPY OF THE FRONT AND BACK OF YOUR HEALTH INSURANCE CARD IN THIS SPACE.**
- 2. IF YOU ARE SCANNING AND E-MAILING OR FAXING YOUR FORMS, INCLUDE COPIES OF THE FRONT AND BACK OF YOUR HEALTH INSURANCE CARD.**
- 3. IF YOU DO NOT CARRY A HEALTH INSURANCE POLICY CHECK HERE: ☐**

The following information is needed for our insurance records. Each applicant is responsible for any and all medical expenses and should be covered by his/her own sickness and accident insurance.

Insurance Company Name: _____ **Policy Number:** _____

Claim Billing Address: _____ **City/State/Zip:** _____

Prescription Plan Name: _____ **Policy Number:** _____

Claim Billing Address: _____ **City/State/Zip:** _____

ADHD MEDICATION QUESTIONNAIRE

Complete this form if the applicant takes medication(s) for ADHD.

1. What is the applicant's diagnosis?

- ☐ Predominantly hyperactive-impulsive
- ☐ Predominantly inattentive
- ☐ Combined hyperactive-impulsive and inattentive

2. Name of *medication(s):

How long has the applicant been taking the medication(s)?

3. Does the applicant take this medication:

- ☐ School Days
- ☐ Everyday
- ☐ As Needed
- ☐ Other:_____

4. **Outward Bound is a school and focus is required. We recommend that applicants taking medications for ADHD bring a supply of that medication to use if necessary.**

Will the medication be brought as recommended above?

- ☐ Yes ☐ No

5. Describe specific symptoms the medication controls:

6. Other comments:

***If you are taking prescription medication(s), you MUST bring them in ORIGINAL PRESCRIPTION BOTTLES with the physician's dosage directions. If possible, bring a double supply.**

Participants will not be permitted to begin their course without their required medications OR with new medications not approved by our Medical Screener.

ASTHMA MEDICATION QUESTIONNAIRE

Complete this form if the applicant takes medication(s) for asthma.

Many applicants with asthma have safely and successfully completed North Carolina Outward Bound courses. Be as detailed as possible.

1. What year was the asthma diagnosed? _____
2. Has hospitalization been required for asthma? ☐ Yes ☐ No
If “Yes”, describe and give dates:
3. Has emergency room treatment been required for asthma? ☐ Yes ☐ No
If “Yes”, describe and give dates:
4. What triggers the asthma? (cold, allergies, exercise, etc.)
Describe:
5. What medication(s)* are used to control the asthma?

MEDICATION	RESCUE OR DAILY USE	DOSAGE INSTRUCTIONS

*If you are taking prescription medication(s), you MUST bring them in ORIGINAL PRESCRIPTION BOTTLES with the physician’s dosage directions. If possible, bring a double supply.

Participants will not be permitted to begin their course without their required medications OR with new medications not approved by our Medical Screener.



NORTH CAROLINA OUTWARD BOUND SCHOOL

The North Carolina Outward Bound School (NCOBS) strives to accommodate applicants who have dietary preferences or dietary restrictions.

All Outward Bound applicants are required to provide medical information related to their medical history or condition. Once all required paperwork is returned, each applicant will be reviewed on a case-by-case basis.

Regarding dietary preference such as vegan or vegetarian, NCOBS can accommodate by:

- Allowing applicants the choice not to eat certain foods/ingredients we provide OR
- Prior to course start, the applicant, medical screener and/or the NCOBS logistics manager have confirmed alternate diet arrangements.

Regarding dietary restrictions, we must be clear that NCOBS cannot guarantee there will be no exposure to known allergens. NCOBS can accommodate by:

- Purchasing foods from manufacturers that have not processed specific allergens on the same equipment.
- When packing out food for an applicant/crew with a dietary restriction(s) only the applicable allergen free foods will be packed at that time to reduce the potential for cross contamination.

Applicants with dietary restrictions need to understand the following NCOBS protocols:

1. Food is stored in its own separate container, in the same facility as known allergens.
2. Containers may have been previously used to store known allergens, though are cleaned and sanitized/bleached between uses.
3. Food is packed using equipment that has previously been used with known allergens, though is cleaned and sanitized/bleached between uses.
4. Personal utensils provided for course participants have previously been in contact with known allergens, though are cleaned and sanitized/bleached between uses.

If the applicant has had an anaphylactic response related to a dietary allergen, NCOBS must consider our remote wilderness area as we determine the appropriateness of our programs for the applicant.

Initial here to confirm you have read and understood the information and acknowledge you (your child) are able to eat foods that have been handled as stated above.



DIETARY ALLERGEN QUESTIONNAIRE

1. Name of Allergen _____

2. Can the allergen be ingested if in trace amounts within a food product? **Yes / No**

3. Reaction(s) when exposed to allergen: (check all that apply)

Reaction	From Ingestion	From Physical Touch	From Inhalation	From Close Proximity
Swelling				
Nausea				
Itching				
Hives				
Vomiting				
Diarrhea				
Anaphylaxis (severe, life threatening allergic reaction)				
Other (please specify) _____				

4. If you checked Anaphylaxis above, please complete the following for each anaphylactic episode:

Anaphylactic REACTION 1

1) Date of reaction: (DD/MM/YR) _____

2) Did you visit the ER/hospital/Urgent care? **Yes / No**

3) If answered yes, please check the level of care provided during the above visit:

- ☐ Observation only (<24hrs, no admittance)
- ☐ Admitted for observation
- ☐ Admitted for advance care (ICU)

4) During the above visit were antihistamine (Benadryl) and/ or epinephrine administered? If yes, please indicate the following:

Medication	Dosage (amount)	Frequency (number of times dosage given)	Duration (time between repeat dosages)
Anti-histamine			
Epinephrine			
Other (please specify) _____			



NORTH CAROLINA OUTWARD BOUND SCHOOL

Anaphylactic REACTION 2 (if applicable)

- 1) Date of reaction: (DD/MM/YR) _____
- 2) Did you visit the ER/hospital/Urgent care? **Yes / No**
- 3) If answered yes, please check the level of care provided during the above visit:
 - ☐ Observation only (<24hrs, no admittance)
 - ☐ Admitted for observation
 - ☐ Admitted for advance care (ICU)
- 4) During the above visit were antihistamine (Benadryl) and/ or epinephrine administered? If yes, please indicate the following:

Medication	Dosage (amount)	Frequency (number of times dosage given)	Duration (time between repeat dosages)
Anti-histamine			
Epinephrine			
Other (please specify) _____			

Anaphylactic REACTION 3 (if applicable)

- 1) Date of reaction: (DD/MM/YR) _____
- 2) Did you visit the ER/hospital/Urgent care? **Yes / No**
- 3) If answered yes, please check the level of care provided during the above visit:
 - ☐ Observation only (<24hrs, no admittance)
 - ☐ Admitted for observation
 - ☐ Admitted for advance care (ICU)
- 4) During the above visit were antihistamine (Benadryl) and/ or epinephrine administered? If yes, please indicate the following:

Medication	Dosage (amount)	Frequency (number of times dosage given)	Duration (time between repeat dosages)
Anti-histamine			
Epinephrine			
Other (please specify) _____			

5. Is there anything else you would like to share regarding the dietary allergen?

ORTHOPEDIC QUESTIONNAIRE

Complete this form if the applicant has any orthopedic conditions.

1. Describe the nature of the applicant's orthopedic condition.
2. Describe the symptom(s) the applicant is experiencing or may experience while on course. What activities trigger these symptoms?
3. What was the date of the first symptom(s)?
4. What was the date of the most recent symptom(s)?
5. How long do the symptom(s) last?
6. What methods (rest, medication, orthopedic equipment, etc.) are used to alleviate or manage symptom(s)?
7. What impact do the symptom(s) have on the applicant's activity level? Be specific.
8. What is the applicant's range of motion? (full, partial, limited, etc.)
9. Describe the applicant's ability to engage in repetitive motion.

FITTING YOUR BACKPACK

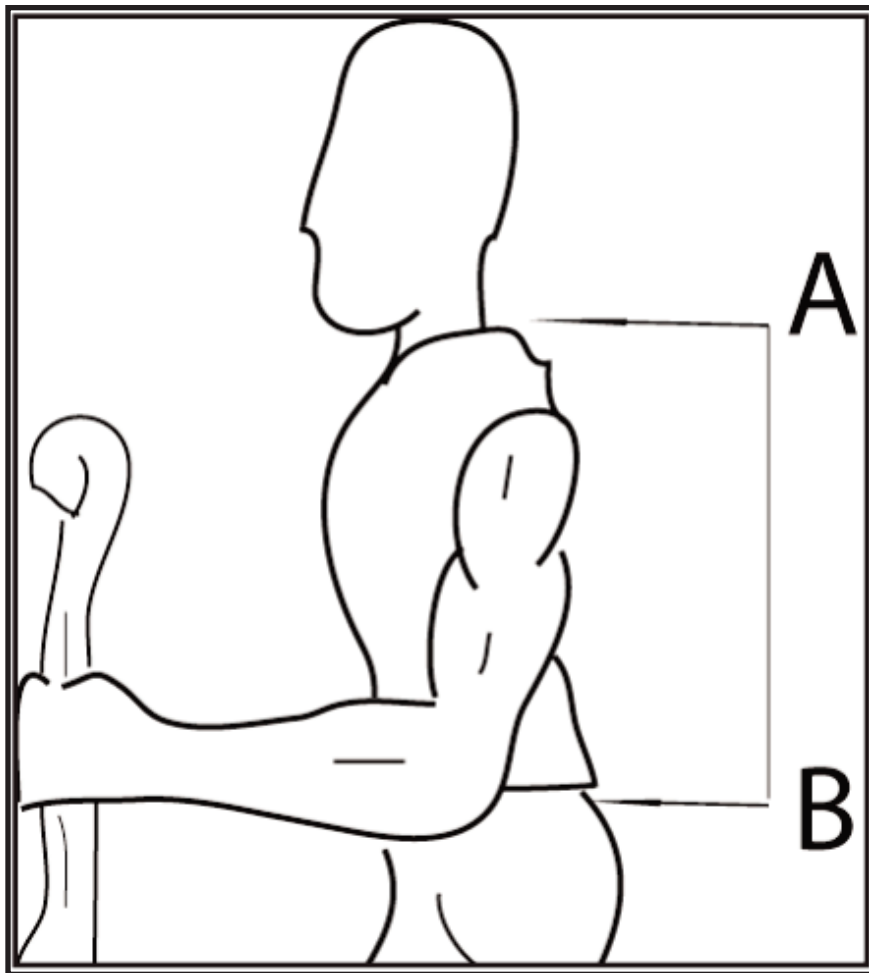
If your course takes place in Florida or the Outer Banks of North Carolina, you do not need to complete this form.

Having a backpack that fits properly is an important part of keeping you comfortable on course. Follow the directions below so North Carolina Outward Bound staff can select the appropriate backpack for you.

Find the most prominent vertebrae at the back of your neck. It's the large bump at about the same level as the top of your shoulders (point A).

Find the top of your hipbone. Follow this point around in a straight line to your spine. (point B).

Lay a measuring tape directly against your spine, and measure the distance between points A and B.



1. Distance between Point A and Point B: _____
2. Measure Hip circumference at hipbone (widest part of hip). To measure, take your tape measure and wrap it around the tops of your hips. This is the "latitude line" where you can feel your iliac crest, the two pointy bones on the front of your hips. Hip Measurement: _____
3. Height: _____ Weight: _____



In consideration of the services of North Carolina Outward Bound School, Inc., and its chartering organization, Outward Bound, Inc., and its affiliated Outward Bound Services Group, and Charter Schools, (collectively referred to as "OB"), participant (and parent or legal guardian of a minor participant) acknowledges and agrees as follows:

Acknowledgment and Assumption of Risks

I understand that participant (and parents) share(s) the responsibility for participant's safety, for managing the risks, and for determining the participant's suitability for the program in which he/she will participate. I have accurately completed any required OB application and medical forms and have reviewed all OB program information provided to me. I agree to obey all OB rules, regulations, and policies (and have my child obey them). I have (or my child has) no mental or physical problems or limitations that might affect my (or my child's) ability to participate that have not been disclosed to OB in writing. I have had the opportunity to ask questions about the program activities and the risks of the program in which I (or my child) will participate.

I understand and acknowledge that the program(s) in which I (or my child) will participate has risks and may be physically strenuous. It is impossible to anticipate every activity in which I (or my child) will engage. Outward Bound offers numerous courses with a wide variety of activities. The list below includes many of those activities. The activities in my (or my child's) course will depend on the program in which I am (or my child is) enrolled but may include: hiking, backpacking, skiing, snowboarding, dog sledding, and/or snowshoeing (on and off trail); camping, including cooking over stoves, open fires or by other means; ropes and/or challenge courses (traversing ropes suspended off the ground, potentially at great heights, swinging or traveling by a cable and pulleys and other such activities); rock, wall or tower climbing; physical problem-solving activities; water activities including flat water or white water boating, rafting, canoeing, or kayaking; ocean sailing or sea kayaking; surfing, snorkeling, or swimming; river crossings; bicycling (including mountain biking); mountaineering (snow, glacier or ice travel or travel at high altitude); horseback riding; jogging or stair climbing; vehicle travel and travel by public, chartered or other conveyance; rescue scenarios (real or simulated); community and other service projects that may involve using tools, power equipment, ladders, or construction materials. I understand that I (or my child) may engage in other activities not listed above. The program plan may be modified for any number of reasons, including convenience, weather, emergencies, or unexpected conditions. Activities may take place in the United States or in foreign countries and may be supervised or unsupervised. In particular, participants may have time alone in remote areas. Participants may also be in urban or other areas with exposure to individuals who are not under OB's supervision or control.

It is impossible to know or list every risk associated with every activity. Risks will depend on the program. Some, but not all, of the risks I (or my child) may encounter include: unpredictable or harsh weather; earthquakes; lightning; exposure to extreme temperatures (high heat or extreme cold); exposure to high altitude, avalanches and rock fall; rapidly moving water including whitewater and rough seas; drowning; wild animals and marine life; disease carrying or poisonous plants, insects, animals, and marine life; improper or malfunctioning equipment; slipping, falling or being struck by objects or persons; risks caused or complicated by any mental, physical, or emotional conditions any participant may have; being separated from other participants and leaders for considerable periods; physical contact with other participants or other individuals; and other natural or man-made hazards. Another risk is the potential misjudgment by OB instructors, volunteers, other staff members, co-participants or contractors related to my (or my child's) participation, including but not limited to decisions regarding my (or my child's) physical condition and capabilities, weather, water, terrain, route or medical treatment. All of these risks are inherent to the activities in my OB program, which means that they cannot be changed or eliminated without altering the essential elements of the activity.

I acknowledge that participating in an OB program involves inherent risks and other risks, hazards, and dangers including some not listed above that can cause or lead to death, injury, illness, property damage, mental or emotional trauma, or disability. Furthermore, activities may take place several hours or days from any medical facility or where communication, transportation, or evacuation is subject to delay. I understand that OB cannot ensure my (or my child's) safety and does not seek to eliminate all of these risks, in part, because they facilitate the educational and other objectives of the program. I agree to assume all of the risks of the activities of my (or my child's) OB program, whether inherent or not and whether described above or not.

Liability Release and Indemnity Agreement

I hereby forever release, waive, and discharge OB, and each of its respective agents, employees, officers, directors, trustees, independent contractors, volunteers, and all other persons or entities acting under their direction and control (collectively referred to as "the Released Parties") from, and agree not to pursue a claim or sue the Released Parties for any liability, claim, or expense in any way associated with my (or my child's)

enrollment or participation in the OB program or the use of any equipment or facilities. Neither I nor anyone acting on my (or my child's) behalf will make a claim against the Released Parties as a result of any injury, illness, damage, death, or loss. This release includes any losses caused or alleged to be caused, in whole or in part, by the negligence, whether active or passive, of the Released Parties to the fullest extent allowed by law (but not for gross negligence) and includes claims for injury, property damage, wrongful death, breach of contract, or any other type of suit.

I further agree to defend and indemnify the Released Parties (to pay or reimburse the Released Parties for money they are required to pay, including attorney's fees and costs) with respect to any and all claims brought by or on behalf of me, my child, a family member, personal representative, estate, a co-participant, or any other person for any claims related to my (or my child's) enrollment or participation in the program or my (or my child's) use of equipment or facilities, including claims that OB instructors, staff, or volunteers were negligent. This includes claims for damage or injury that is finally determined to have been caused by my (or my child's) negligent conduct or intentional misconduct. This indemnity includes payment for attorney's fees and costs incurred by the Released Parties in defending a claim or suit if the claim or suit is withdrawn or where a court determines that the Released Parties are not liable for the injury or loss.

The National Park Service and certain Forest Services may not allow for the assumption of risks other than the inherent risks or for the release of liability for claims of negligence. Therefore, for activities that occur on lands controlled by these agencies where and to the extent that such a prohibition is in writing for that particular location, program, or permit at the time of the incident and found by a court of proper jurisdiction to be enforceable as a matter of law, the assumption of risk in the above paragraph is limited to assuming the inherent risks; the release of liability is inapplicable; and the indemnity agreement is limited to claims brought by or on behalf of a co-participant or person other than the student or a family member of the student. The assumption of all risks, the entire indemnity provision, and the release of liability shall remain in full force and effect for all activities or any portion of activities which do not transpire on lands controlled by these federal provisions. The indemnity provision for payment of attorney's fees when a suit is withdrawn or where a court determines that the Released Parties are not liable applies to all activities regardless of where they take place.

Additional Provisions

I agree that the substantive law of North Carolina (but not any law that would apply the laws of another jurisdiction) governs this document and any dispute or suit I have (or my child has) with the Released Parties. Any mediation, suit, or other proceeding must be filed or entered into only in North Carolina.

The assumption of risk, release, indemnity agreement, and all other provisions in this document are intended to be interpreted and enforced to the fullest extent allowed by law. Any portion of this document deemed unlawful or unenforceable is severable and shall be stricken without any effect on the enforceability of the remaining provisions, which shall continue in full force and effect. OB has permission to use my (or my child's) photo, image or video in promoting OB, including website and internet postings. OB reserves the right to remove any participant from the program when staff or an instructor believes, in his/her sole discretion, the participant presents a safety concern or medical risk, is disruptive, or acts in any manner detrimental to the program. If I am dismissed or depart (or my child is dismissed or departs) for any reason, I will be responsible for all costs of early departure whether for medical reasons, dismissal, personal emergencies, or otherwise.

I HAVE CAREFULLY READ, UNDERSTAND, AND VOLUNTARILY SIGN THIS DOCUMENT. I UNDERSTAND THAT I AM SURRENDERING CERTAIN LEGAL RIGHTS. I AGREE THAT THIS FORM SHALL BE BINDING ON ME, MY MINOR CHILDREN AND OTHER FAMILY MEMBERS, AND MY HEIRS, EXECUTORS, REPRESENTATIVES, AND ESTATE. I HEREBY WARRANT THAT I HAVE LEGAL AUTHORITY TO ACT ON MY CHILD'S BEHALF. I AGREE, ON MY OWN, AND ON MY CHILD'S BEHALF, TO THE TERMS AND CONDITIONS IN THIS DOCUMENT.

If participant is under the age of 18 (or if participant is a resident of Alabama and is under the age of 19) (or if participant is a resident of Mississippi and is under the age of 21) at the time this document is signed, a parent or legal guardian must sign the release in addition to the participant signing.

Participant signature

Date

Print name here

Date of Birth and Age

Parent or Legal Guardian signature

Date

Print name here



CONSENT FORM AND PRE-COURSE IMPRESSION

You have applied for a course with the North Carolina Outward Bound School (NCOBS). As part of your application process, we ask that you complete a pre- and post-course impression. Your responses from your course impressions help us evaluate our programs and may be used in a study of outcomes regarding our curriculum.

The survey conducted by Whitney H. Montgomery, Executive Director of NCOBS, will be in cooperation with Dr. Andrew Bobilya, NCOBS instructor and Associate Professor of Parks and Recreation Management at Western Carolina University.

PROCEDURES

Please read this form and sign where indicated then answer the 20 questions on the pre-course impression. If you are under 18 years of age, a parent/guardian must also sign. This process should take less than 10 minutes of your time. Return both completed forms along with your other required forms. Towards the end of your wilderness experience, you will be asked to complete a post-course impression. Both your completed pre-course impression and post-course impression will help us determine the impact Outward Bound is having on our course participants.

NCOBS is also interested in conducting a long term, longitudinal study in which we will contact course participants a number of years following their course completion. The purpose of such a study would be to measure the lasting impact of an Outward Bound course on participants.

Please check the box if you are willing to participate and be contacted if such a study were to be conducted.

☐ I am willing to participate

CONFIDENTIALITY

The responses of your course impressions will be shared with NCOBS and among the study team and its assistants. Any study of outcomes we publish will not include any information that will make it possible to identify a course participant.

STATEMENT OF CONSENT

I have read the above information. I consent to my participation. Parent/guardian name and parent/guardian signature are required for students under 18 years of age.

Student Name:_____ Age:_____ Course Number:_____

Student Signature:_____ Date:_____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____ Date:_____

Thank you for your participation in advance!

Whitney H. Montgomery

Andrew J. Bobilya

PRE-COURSE SURVEY

This survey, paired with another survey you will complete at course end, helps us evaluate our programs. Your responses may be used in a study of our curriculum outcomes.

Applicant Name: _____ Course Number: _____

Please rate the following statements by choosing a number from 1-7 using the scale below.

	Strongly Disagree			Neutral		Strongly Agree	
1. I can accomplish most things I set my mind to.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
2. Community service is important to me.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
3. I am motivated to set and accomplish goals for my education or for my life/career.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
4. I have a sense of direction and purpose in my life.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
5. I am able to work productively with others.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
6. I take responsibility in caring for the environment.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
7. I am sensitive to the needs and feelings of others.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
8. I listen when people talk to me.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
9. I respect and feel a connection to nature.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
10. I have a personal commitment to physical fitness.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
11. I find peaceful solutions to conflict.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
12. I feel proud of myself.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
13. I am flexible in my thinking and ideas.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
14. I contribute when I work in a group.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
15. I realize my potential.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
16. I help others when they need it.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
17. I balance the time I spend on work/school and leisure time.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
18. I recognize that others may be different from me.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
19. I deal well with unexpected events.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
20. I realize the value of and embrace the differences that others may have from me.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7