# North Carolina Outward Bound ~ FINS

**CINS/FINS Program**
Children and Families in Need of Services

**The Population**

Our students are troubled adolescents, 12-17 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, Duval, Flagler, Lake, Orange, Osceola, Polk, Seminole, St. Johns and Volusia. **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: smadmissions@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.

OUTWARD BOUND

4 PAGE PARTICIPANT MEDICAL RECORD

RETURN

OFFICE USE ONLY

| FOLLOW-UP |
|---|
| APPROVAL |

# PART I – GENERAL INFORMATION

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

## Applicant

Title: ❑Dr. ❑Mr. ❑Mrs. ❑Miss ❑Other: _____

Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____

Cell Phone: _____

E-mail: _____

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 1 (if applicant is under the age of 21)

Title: ❑Dr. ❑Mr. ❑Mrs. ❑Miss ❑Other: _____

Name: _____

Relationship to Applicant: _____

Address: _____

City/State/Zip: _____

E-mail: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Occupation: _____

## Parent/Custodial Guardian 2 (if applicant is under the age of 21)

Title: ❑Dr. ❑Mr. ❑Mrs. ❑Miss ❑Other: _____

Name: _____

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 the age of 21)

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: _____

**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 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 PRSENT MEDICAL PROBLEMS

**A. If you answer "yes" to any of the items, please explain below. Include the following:**

- Specific symptoms that are occurring
- How often symptom/condition occurs
- How long symptom/condition lasts
- How you care for symptom/condition
- Date of last occurrence
- 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 | Chest Pain / Pressure | | | |
| 6 | Circulation Problems | | | |
| 7 | Frostbite | | | |
| 8 | Heatstroke | | | |
| 9 | Frequent Dizziness / Fainting | | | |
| 10 | History of Altitude Sickness | | | |
| 11 | Severe Headaches / Migraines | | | |
| 12 | Head injury with neurological impairment | | | |
| 13 | Tuberculosis / Positive TB test | | | |
| 14 | Asthma or COPD | | | |
| 15 | Active or History of Hepatitis | | | |
| 16 | Lyme Disease | | | |
| 17 | Seizure Disorder / Epilepsy | | | |
| 18 | Seizure within past 6 months | | | |
| 19 | Bleeding / Blood Disorder | | | |
| 20 | Sickle Cell Anemia | | | |
| 21 | Sickle Cell Trait | | | |
| 22 | Hypoglycemia (low blood sugar) | | | |
| 23 | Diabetes | | | |
| 24 | Cancer | | | |
| 25 | Thyroid Problems | | | |
| 26 | Gastro-intestinal Problems | | | |
| 27 | Special Diet | | | |
| 28 | Food Allergies | | | |
| 29 | Kidney Problems | | | |
| 30 | Urinary Tract Problems | | | |
| 31 | Bedwetting | | | |
| 32 | Orthopedic Problems | | | |
| 33 | Broken Bones within past year | | | |
| 34 | Hearing Impairment | | | |
| 35 | Vision Impairment | | | |
| 36 | Skin Problem | | | |
| 37 | Motion Sickness | | | |
| 38 | Sleep Walking | | | |
| 39 | PMS/Menstrual Problems (severe) | | | |
| 40 | Currently Pregnant | | | |
| 41 | Medical Equipment/ Devices | | | |
| 42 | Other | | | |
| 43 | Other | | | |

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

❑ NONE
(OR LIST TO RIGHT)

| Allergy<br>List Below | Reaction<br>List Below | Medication Required<br>(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<br>List Below | Taken For<br>Symptom/Condition | Dosage<br>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 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. IMMUNIZATIONS

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

## F. PERSONAL HISTORY – BASED ON PAST YEAR

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

| Y | N | | Y | N | |
|---|---|---|---|---|---|
| ❑ | ❑ | ADHD | ❑ | ❑ | Autism Spectrum Disorder |
| ❑ | ❑ | Anxiety Disorder | ❑ | ❑ | Bipolar Disorders |
| ❑ | ❑ | Depressive Disorder | ❑ | ❑ | Disruptive and Conduct Disorder |
| ❑ | ❑ | Eating Disorder | ❑ | ❑ | Intellectual Disability |
| ❑ | ❑ | Learning Disability | ❑ | ❑ | Obsessive-Compulsive Disorder |
| ❑ | ❑ | Personality Disorder | ❑ | ❑ | Schizophrenia Spectrum Disorder |
| ❑ | ❑ | Substance Related Disorder | ❑ | ❑ | Trauma and Stressor Related Disorder |
| ❑ | ❑ | Other: _____ | | | |

1b. Have you received treatment or therapy for any of the following, either currently or in the past year?

| Y | N | | Y | N | |
|---|---|---|---|---|---|
| ❑ | ❑ | Medication(s) | ❑ | ❑ | Residential Treatment |
| ❑ | ❑ | Out Patient Counseling | ❑ | ❑ | Psychiatric Hospitalization |
| ❑ | ❑ | Day Treatment | | | |

**2.** 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**

**3.** Provide the name, telephone number and email address of your therapist and/or prescribing physician:

Prescribing Physician: _____ Therapist: _____
Phone Number: _____ Phone Number: _____
Fax Number: _____ Fax Number: _____
Email: _____ Email: _____

## G. LIFESTYLE

| | | | | |
|---|---|---|---|---|
| Do you use alcohol? | ❑ Yes ❑ No | How much? _____ | How often? _____ | |
| Do you use tobacco? | ❑ Yes ❑ No | How much? _____ | How often? _____ | |
| Do you use recreational drugs? | ❑ Yes ❑ No | Which one(s)? _____ | How often? _____ | |
| Do you have a history or current problem with substance abuse or dependency? | ❑ Yes ❑ No | How long? _____ | | |
| Have you been suspended or expelled from school in the past year? | ❑ Yes ❑ No | Date(s) _____ | Reason _____ | |
| Have you been on probation or had any involvement with the justice system? | ❑ Yes ❑ No | Date(s) _____ | Reason _____ | |

## H. CURRENT EXERCISE ACTIVITY

**Please list the activities you engage in daily or weekly that indicate your current fitness level. Be sure to include all activities. 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 you program.**

❑ **NONE**
**(OR LIST TO RIGHT)**

| Activity | Frequency | Time/Distance | Leisurely | Moderately | Intensely |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## I. SWIMMING ABILITY (CHECK ONE)

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

OUTWARD BOUND

RETURN

# PHYSICIAN'S EXAM

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

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 six months of course start date.**

Patient's Name: _____

Height: _____ ft. _____ inches Weight _____lbs. BMI _____

Please indicate if the patient is over or underweight:

Overweight by _____lbs. Underweight by _____lbs.

Blood Pressure: _____

If BP is over 150/90, please repeat:

Second Reading: _____

Pulse Irregularities: ❑ Yes ❑ No

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

## B. PHYSICIAN'S EXAM **Information must be based upon examination done within six months of course start date.**

**Check box if normal; describe if abnormal.**

- ❑ Eyes/Ears _____
- ❑ Nose _____
- ❑ Throat/Mouth _____
- ❑ Lymph Nodes _____
- ❑ Thorax/Lungs _____
- ❑ CNS _____
- ❑ Thyroid _____
- ❑ Heart _____
- ❑ Heart Murmur _____
  - ❑ If Murmur, functional _____
- ❑ Abdomen _____
- ❑ Hernia _____
- ❑ Peripheral Vessels _____
- ❑ Neck _____
- ❑ Back _____
- ❑ Shoulders _____
- ❑ Knees _____
- ❑ Ankles/Feet _____
- ❑ Extremities _____
- ❑ Skin _____
- ❑ Other _____

**Check if the patient is diagnosed with any of the following conditions. If so, indicate if the condition is controlled/stable.**

- ❑ Allergies - food _____
- ❑ Allergies – other _____
- ❑ Asthma _____
- ❑ Seizures _____
- ❑ Hypertension _____
- ❑ High Cholesterol _____
- ❑ Diabetes _____
- ❑ Other _____

## C. SUMMARY OF ACTIVE MEDICAL PROBLEMS AND/OR RESTRICTIONS ❑ NONE (or list below)

_____

_____

_____

_____

## 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 is over 40, has a sedentary lifestyle, is significantly overweight, 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)**
- **Smoking**
- **Diabetic requiring medication**
- **Known abnormally high cholesterol level, or on a diet or medication for lipid abnormality**
- **Family history (parent/sibling) of heart attack, coronary artery by-pass/angioplasty, or unexplained death before age 55**
- **Current cardiovascular disease**
- **History of prior heart disease**
- **Unexplained chest pain/pressure, shortness of breath, heart palpitations, sweats, exertional dizziness or fainting 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? ❑ Yes ❑ No

Has this patient had an exercise stress test within the past year? ❑ Yes ❑ No

Please forward a copy of the test summary. ❑ Enclosed ❑ Will FAX to: _____

**Participation in this program will depend upon the interpretation of the test.**

## D. PHYSICIAN RECOMMENDED REFFERALS

Do you feel further examination or specialty referral is indicated for this patient prior to participation in an Outward Bound program? ❑ Yes ❑ No Please explain: _____

Consulting Opinion: ❑ Enclosed ❑ Will FAX to: _____

## E. IMMUNIZATION

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

## F. KNOWN MEDICATIONS If any please list. ❑ NONE (or list below)

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

## G. ADDITIONAL COMMENTS ❑ NONE (or list below)

_____

_____

_____

## H. PHYSICIAN'S SIGNATURE

**How long have you known the applicant?** _____

**Physician's Name (print):** _____

**Physician's Signature:** _____

**Date of Exam:** _____ Must be within six months of start date.

**Telephone:** _____ **FAX:** _____

**Email:** _____