



## **MEDICAL RECORD - ADULT**

### **This form does not require a physician's exam**

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

Take time to answer questions as they apply to your physical and mental health. Provide as much detail as possible. 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 web page.

### **ADDITIONAL FORMS**

Depending on your course and the answers you provided while completing your Health History Questionnaire, you may need to fill out additional forms to complete your application process. These additional forms will be indicated in your Registration Email and should be returned with all other required 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 web page.

### **QUESTIONS**

The Student Services Department can be reached by phone on 800-878-5258 or by email at [studentservices@ncobs.org](mailto:studentservices@ncobs.org)



FOLLOW-UP

APPROVAL

4 PAGE PARTICIPANT MEDICAL RECORD

OFFICE USE ONLY

**PART I – GENERAL INFORMATION**

PROGRAM/COURSE NUMBER \_\_\_\_\_ START DATE \_\_\_\_\_

**APPLICANT**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_

Title:  Dr.  Mr.  Mrs.  Ms.  Miss  Other \_\_\_\_\_  
Age at Program Start: \_\_\_\_\_ DOB: \_\_\_\_\_  
Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.  
Sex:  Male  Female  Intersex  
Gender:  Male  Female  Non-Binary  Transgender  
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: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_  
Cell: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

**Ethnicity** (optional)

- Asian
- Multi-Ethnic
- Hispanic or Latino
- Caucasian (Non-Hispanic)
- Native Hawaiian or Pacific Islander
- African American
- American Indian/Alaskan Native
- Unknown
- 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<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.

| Medication<br>List Below | Taken For<br>Symptom/Condition | Dosage<br>Size/Frequency | Date<br>Started | Current Side<br>Effects | Expiration<br>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.

- ADHD
- Anxiety Disorder
- Depressive Disorder
- Eating Disorder
- Learning Disability
- Personality Disorder
- Substance Related Disorder
- Other: \_\_\_\_\_
- Autism Spectrum Disorder
- Bipolar Disorder
- Disruptive and Conduct Disorder
- Intellectual Disability
- Obsessive Compulsive Disorder
- Schizophrenia Spectrum Disorder
- Trauma and Stressor Related Disorder

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?

- Medication(s)
- Out Patient Counseling
- Day Treatment
- Residential Treatment
- Psychiatric Hospitalization

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.

- Do you use alcohol? \_\_\_\_\_
- Do you use tobacco? \_\_\_\_\_
- Do you use recreational drugs or marijuana? \_\_\_\_\_
- Do you have a history or current problem with substance abuse or dependency? \_\_\_\_\_
- Have you been suspended or expelled from school in the past year? \_\_\_\_\_
- 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



## IV - EXPULSION/EARLY DEPARTURE POLICY AND COMMITMENT TO EXCELLENCE

Kurt Hahn, the founder of Outward Bound, attributed the success of Outward Bound to the activities, which developed a positive attitude towards challenge and an ethic of service and compassion for others. His objective was to nurture youth with convictions that were rooted in four basic concepts: physical fitness, craftsmanship, self-reliance, and above all, compassion. The intent was to equip young people “to affect what is recognized to be right, despite hardships, despite dangers, despite inner skepticism, despite boredom, despite mockery from the world, despite emotion of the moment.” He saw this as central to survival in a complex modern society. Today, there are over 50 Outward Bound schools and centers around the world using wilderness and urban environments to teach values and skills to people of all ages. Our aim is to help build self-esteem, self-confidence as well as concern and respect for others.

With that said, it is important that each participant come with a willingness to open themselves to the journey that Outward Bound begins. Every instructor relies on the establishment of some basic rules designed to maintain physical and emotional safety. These rules are non-negotiable, reasonable and basic. All courses are a bit different but, at a minimum, we will expect the following:

- Be open to meeting new people
- Try your hardest and participate to your fullest
- Make mistakes and learn from them
- No exclusive relationships, sexual activity or cliques
- Follow all physical and emotional safety guidelines
- No derogatory language, drugs, alcohol, tobacco or physical violence

**Early Departure:** Our intent is to support students so they can successfully complete their course. However, there are circumstances that can lead to students not completing their course.

Early departures can be due to medical issues, homesickness, low motivation or expulsion. Expulsion can result from inappropriate use of prescription or non-prescription medications, use of tobacco or tobacco products, use of alcohol, physical violence or derogatory language. A student will be removed from course by our staff if he/she exhibits behavior deemed inappropriate to our school’s mission and policy. In addition, if we determine that any relevant information was misrepresented or not disclosed, we have the right to remove the student from the course. You will also be charged a \$100 evacuation fee.

If a student is not able to complete the course for any reason, parents (as appropriate\*) will be contacted to arrange for his/her return home.

**Disclosure and Policy Agreement:** The information provided on these forms and all other forms and questionnaires is a complete and accurate representation of my or my child’s physical and psychological condition and history.

**Should a student leave course for any reason, there is no refund. Therefore, we HIGHLY encourage families to purchase trip insurance (See Financial Commitment booklet).**

I have read the above and, without undue influences from others, agree to abide by the rules and standards of the North Carolina Outward Bound School. Should I leave the course early, I am aware that I will be held responsible for evacuations costs.

**Parents/Guardians:** If your child leaves course early, you will be contacted to arrange for his/her return home. You will also be responsible for any evacuation costs.

\*If your child is on a course for ages 18+, please read our Release of Information Waiver.

**Participant Signature:** \_\_\_\_\_

**Parent/Guardian\* Signature:** \_\_\_\_\_

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

# V - RELEASE OF INFORMATION WAIVER

## Tobacco, Alcohol, Illegal Drugs and Behavior Policy

Students cannot possess or use tobacco products, alcohol, illegal drugs and/or medications NOT listed on their medical forms while on course (including any intra-course travel days or breaks). Students must also exhibit appropriate behavior and a high level of commitment. Refer to the Expulsion/Early Departure Policy and Commitment to Excellence on page six (6).

If a student fails to uphold these expectations, the student risks immediate expulsion from the course.

This policy is in effect from the point of pick up at course start to drop off at course end.

**Courses age 18+:** If a student violates this policy, NCOBS staff may expel the student immediately. The student (or the financially responsible party named below) is responsible for any airline rebooking fees.

**Semester Courses with an International Component:** If a student has violated this policy previous to the start of the international component and if NCOBS staff doubts the student’s ability or willingness to abide by the policy once out of country, the North Carolina Outward Bound School may expel the student prior to the international component. The student (or the financially responsible party named below) is responsible for airline rebooking fees.

**Intra-course Travel and Break Days:** There may be intra-course travel or break days during courses 50 days and longer. During these days, students are driven to town for laundry, dining and general errands. All policy expectations remain in effect.

The North Carolina Outward Bound School’s responsibility for an expelled student officially ends at the airport; therefore, **IF THE INDIVIDUAL REFUSES TO BOARD THE PLANE**, North Carolina Outward Bound **WILL NO LONGER BE RESPONSIBLE FOR THAT INDIVIDUAL’S SAFETY AND WELL BEING** as they are no longer a student of the North Carolina Outward Bound School.

## RELEASE OF INFORMATION WAIVER

Due to the unique nature and cost of these courses, North Carolina Outward Bound requires approval from the applicant to contact the financially responsible party if a policy violation occurs during the course. NCOBS acknowledges that we are targeting an adult population (18+); however, we also acknowledge, in most instances, the students are not the individuals financially supporting their experience.

Should a policy violation occur that will result in expulsion or other consequences deemed appropriate by the North Carolina Outward Bound School, staff will alert the party noted below. The staff will be able to explain in detail the circumstances that have led us to take action.

Name of Financially Responsible Party: \_\_\_\_\_ Best Phone Number: \_\_\_\_\_

Relationship to Applicant: Best \_\_\_\_\_ Email address: \_\_\_\_\_

Financially Responsible Party Signature: \_\_\_\_\_

Participant Name: \_\_\_\_\_ Participant Age: \_\_\_\_\_

Participant Signature: \_\_\_\_\_



**VI - 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 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:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_

**Claim Billing Address:** \_\_\_\_\_ **City/State/Zip:** \_\_\_\_\_

**Prescription Plan Name:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_

**Claim Billing Address:** \_\_\_\_\_ **City/State/Zip:** \_\_\_\_\_