



MEDICAL RECORD - YOUTH

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



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

MUST BE COMPLETED BY PARENT/GUARDIAN, NOT APPLICANT. YOU MAY INCLUDE A LETTER IF YOU HAVE ADDITIONAL INFORMATION YOU WOULD LIKE OUR INSTRUCTIONAL STAFF TO KNOW.

North Carolina Outward Bound seeks students who are motivated to learn outdoor leadership skills, build self-esteem, are in good emotional and physical health and are socially responsible. We are not an appropriate choice for individuals dealing with behavioral, motivational or rehabilitation issues. We reserve the right to deny admission to those who do not meet these standards.

1. With whom is the child currently living? Please indicate names and check appropriate box(es).

Adults: _____

☐ Birth Parent(s) ☐ Step-Parent(s) ☐ Guardian(s) ☐ Adoptive Parent(s) ☐ Other _____

Brothers/Sisters: _____

2. Who has legal custody of the child?

Name: _____

Name: _____

3. What led to the decision that your child apply to Outward Bound? What are you hoping he/she will gain?

4. Are consequences and rewards a part of his/her attendance? ☐ Yes ☐ No

If "Yes," what are the consequences/rewards and why are they being offered?

5. Does your child understand that Outward Bound is physically and emotionally challenging, is not a recreational summer camp and involves living with a new peer group?

☐ Yes ☐ No

If "No," what steps are you taking to prepare your child for this course?

6. List your child's behaviors/attitudes/traits that may be challenging for our staff. What insight could you pass along that would help us as we work with your child?

7. Briefly describe your child's interests, hobbies and use of free time.

8. How might your child respond to physical stress and new social situations?

9. What is your child's relationship with peers and what is the typical role your child assumes within groups?

10. What is your child's current academic status? Is his/her behavior a problem at school?

11. Does your child have any special needs or learning disabilities? ☐ Yes ☐ No
If "Yes," please explain.

12. Is your child experimenting with or abusing drugs and/or alcohol? ☐ Yes ☐ No
If you checked "YES," please provide details on a separate sheet of paper.

13. Has your child been suspended/expelled from school? ☐ Yes ☐ No
If you checked "YES," please provide details on a separate sheet of paper.

14. Is your child currently in treatment? ☐ Yes ☐ No
If you checked "YES," please provide details on a separate sheet of paper.

15. Has your child been involved with the Juvenile Justice System? ☐ Yes ☐ No
If you checked "YES," please provide details on a separate sheet of paper.

16. NCOBS may notify your hometown newspaper of your child's course completion. NCOBS may write a brief article about Outward Bound which will include your child's name. **Permission:** ☐ Yes ☐ No

If yes, _____
Hometown newspaper City State

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

Parent/Guardian Name: _____

PART IV - APPLICANT QUESTIONNAIRE**TO BE COMPLETED BY APPLICANT, NOT PARENT/GUARDIAN**

Your answers will help our instructors plan your course activities and will help them learn more about you. Mark the answers you feel are right for you. Add comments if these words do not express your feelings.

1. Who made the decision that you attend Outward Bound?

- ☐ Myself ☐ My parents/guardians ☐ Both

2. On Outward Bound, I will:

- ☐ Try hard and give 100% ☐ Work enough to finish ☐ Try a little

3. Are you getting in shape?

- ☐ Yes ☐ No ☐ I plan to

4. Do you want to attend Outward Bound?

- ☐ Yes ☐ No

5. Indicate your level of commitment to attend Outward Bound on the scale below.

- | | | | | | | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|-----------------------------|
| <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 | <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | <input type="checkbox"/> 10 |
| I DO NOT | | | I am NOT SURE if I | | | | I DO want | | |
| want to attend. | | | want to attend. | | | | to attend! | | |

6. Why do you want (or not want) to attend Outward Bound?

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

8. Do you have any concerns about attending Outward Bound?

9. How do you get along with your parent(s)/guardian(s) and other family members?

10. How do you handle the following:

New situations?

Physical challenges?

Stress or conflict?

Teachers or authority figures?

11. When you get mad, how do you express your anger?

12. Have you ever been in trouble at school or in trouble with the law? ☐ Yes ☐ No

If "Yes," please explain.

13. What grade will you be going into this fall?

☐ 8th ☐ 9th ☐ 10th ☐ 11th ☐ 12th ☐ College/University

School/College/University Name: _____

14. If your course includes a rock climbing component, indicate your shoe size: _____ ☐ Mens ☐ Womens
(NCOBS provides rock climbing shoes. However, you can choose to bring your own climbing shoes.)

Applicant Name: _____

V-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.

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 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:** _____