



4 PAGE PARTICIPANT MEDICAL RECORD

OFFICE USE ONLY

APPROVAL

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)

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

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. 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 will not receive a refund of tuition.

SIGNATURE REQUIRED I understand the above paragraph and agree to its terms. 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. 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.

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.)

PLEASE RETURN TO admissions@hiobs.org or FAX: 888-695-1417 WITHIN 5 DAYS

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
High Blood Pressure	_____
Heart Disease	_____
Heart Murmur	_____
Irregular Heartbeat/Palpitations	_____
Chest Pain/Pressure	_____
Circulation Problems	_____
Frostbite	_____
Heatstroke	_____
Frequent Dizziness/Fainting	_____
History of Altitude Sickness	_____
Severe Headaches/Migraines	_____
Head Injury w/Neurological Impairment	_____
Tuberculosis/Positive TB test	_____
Asthma or COPD	_____
Active or History of Hepatitis	_____
Lyme Disease	_____
Seizure Disorder/Epilepsy	_____
Seizure within past 6 months	_____
Bleeding/Blood Disorder	_____
Sickle Cell Anemia	_____
Sickle Cell Trait	_____
Hypoglycemia (low blood sugar)	_____
Diabetes	_____
Cancer	_____
Thyroid Problems	_____
Gastro-intestinal Problems	_____
Special Diet	_____
Food Allergies	_____
Kidney Problems	_____
Urinary Tract Problems	_____
Bedwetting	_____
Orthopedic Problems	_____
Broken Bones within past year	_____
Hearing Impairment	_____
Vision Impairment	_____
Skin Problem	_____
Motion Sickness	_____
Sleep Walking	_____
PMS/Menstrual Problems (severe)	_____
Currently Pregnant	_____
Medical Equipment/Devices	_____
Other	_____

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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.

- | | |
|----------------------------|--------------------------------------|
| ADHD | Autism Spectrum Disorder |
| Anxiety Disorder | Bipolar Disorder |
| 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: | |

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) | Residential Treatment |
| Out Patient Counseling | Psychiatric Hospitalization |
| 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.

- Do you use alcohol? _____
- Do you use tobacco or nicotine products? _____
- 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

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