HURRICANE ISLAND
OUTWARD BOUND SCHOOL

PHYSICIAN'S EXAM

RETURN TO: ADMISSIONS DEPARTMENT
Hurricane Island Outward Bound School
P.O. Box 800, Camden ME 04843
Tel: 855-802-0307 | FAX: 888-695-1417
Email: admissions@hiobs.org

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:

- **Immersion in cold water**
- **Running on uneven ground**
- **Remote wilderness setting**
- **Rowing for extended periods**
- **Rock climbing or a ropes course—extreme heights**

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 one year 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 one year 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 _____

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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)

_____

_____

_____

_____

_____

D. 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.

E. 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: _____

F. IMMUNIZATION

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

G. 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)

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H. ADDITIONAL COMMENTS ❑ NONE (or list below)

_____

_____

_____

_____

_____

I. PHYSICIAN'S SIGNATURE

How long have you known the applicant?

_____

Physician's Name (print):

_____

Physician's Signature:

_____

Date of Exam: _____ Must be within 1 year of start date.

Telephone: _____ **FAX** : _____

Email: _____