PLEASE RETURN TO:
groups@hiobs.org
or fax: 866.397.8619

OUTWARD BOUND

4 PAGE PARTICIPANT MEDICAL RECORD

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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.)

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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 often symptom/condition occurs
- How long symptom/condition lasts
- How you care for symptom/condition
- Date of last occurrence
- 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	_____

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
- ☐ 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 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