



OUTWARD BOUND

Instructor Notes

Participant/Physician Confidential Medical Record

Complete as directed and return to:

Philadelphia Outward Bound Center
3250 West Sedgeley Drive
East Fairmount Park
Philadelphia, PA 19130

Phone: (215) 232-9130
FAX: (215) 232-9162
aburrell@outwardbound.org

Office Use Only

Follow-up

Approval

Pages 1 - 4 to be completed by the applicant and provided to the examining MD, DO, CRNP, or PA

PART I General Information

Course _____ Starting Date _____

Applicant	
Name _____	Address _____ Apt. # _____
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	City/State/Zip _____
Age at Course Start _____ DOB ____/____/____	Daytime Telephone (____) _____
Height _____ ft. _____ ins.	Evening Telephone (____) _____
Weight _____ lbs.	FAX (____) _____ Cell (____) _____
Occupation _____	email _____
Social Security # _____ - _____ - _____	
Parent/Guardian	Parent/Guardian
Name _____	Name _____
Relationship _____	Relationship _____
Address _____	Address _____
City/State/Zip _____	City/State/Zip _____
Occupation _____	Occupation _____
Home Telephone (____) _____	Home Telephone (____) _____
Work Phone (____) _____ Cell (____) _____	Work Phone (____) _____ Cell (____) _____
FAX #/email _____	FAX #/email _____
Emergency Contact (not parent/guardian)	Family Physician
Name _____	Name _____
Relationship _____	Telephone # (____) _____
Daytime Telephone # (____) _____	FAX # (____) _____
Evening Telephone # (____) _____	
Cell Phone # (____) _____	Do you speak/understand English?
	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ethnic Background (Optional)	
<input type="checkbox"/> Asian	<input type="checkbox"/> Caucasian (Non-Hispanic)
<input type="checkbox"/> Multi-Ethnic	<input type="checkbox"/> Native Hawaiian or Pacific Island
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> African American
<input type="checkbox"/> Other	<input type="checkbox"/> American Indian/Alaskan Native
	<input type="checkbox"/> Choose Not to Answer
	<input type="checkbox"/> Do Not Know Ethnicity
Insurance Information Each participant is responsible for any medical expenses and should be covered by his/her own illness and accident insurance. Please attach a photocopy of both the front and back of your insurance card.	
The following questions must be answered for our records: DO YOU HAVE INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Insurance Company _____	Policy/Certificate # _____
Prescription Plan # _____	Telephone # (____) _____
Signature Required	
<i>Consent is hereby given for the applicant to attend an Outward Bound wilderness program and permission is given for any emergency anesthesia, operation, hospitalization or other treatment that may become necessary. All information will remain confidential. You should know that over the years, many students with a variety of medical/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 and your fellow students. If you arrive at the program start with a pre-existing condition or injury that has not been indicated on your medical form and you are subsequently forced to leave the program because of that condition, you will be charged an evacuation fee and will not receive a refund of tuition.</i>	
_____	_____
Parent's/Guardian's Signature (if applicant is under legal age)	Date
_____	_____
Applicant's Signature	Date

B. Allergies

(Including allergies to medicines, foods, insect bites/stings)

NONE or...

Allergy <small>List Below</small>	Reaction	Medication Required <small>(if any)</small>

C. Medications You Are Currently Taking

(If psychiatric medication, please list any taken within the past 2 months)

NONE or... list any you are using including psychiatric, over-the-counter, inhalers, herbal supplements

Medication <small>List Below</small>	Taken For <small>Symptom/Condition</small>	Dosage <small>Size/Frequency</small>	Date Started	Current Side Effects <small>(if any)</small>

NOTE: If you are currently taking a medication, bring double amounts in separate, non-breakable, waterproof containers along with dosage instructions.

D. Immunization

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

E. Hospitalizations/Emergencies/Urgent Care

NONE or... please list any hospital, emergency department, or urgent care visits within the past 2 years

Date of Visit/Admittance	Reason	Length of Stay

F. Personal History

#	Counseling History (Based upon past two years)
1	Have you been diagnosed or treated for any of the following within the past 2 years? <input type="checkbox"/> Attention Deficit Disorder (ADD) <input type="checkbox"/> Impulse Control Disorder <input type="checkbox"/> Personality Disorder <input type="checkbox"/> Adjustment Disorder <input type="checkbox"/> Learning Disorder <input type="checkbox"/> Pervasive Developmental Disorder <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Disruptive Behavior Disorder <input type="checkbox"/> Mood Disorder <input type="checkbox"/> Substance Related Disorder <input type="checkbox"/> Eating Disorder
2	Have you received treatment or therapy for any of these conditions? <input type="checkbox"/> Medication(s) <input type="checkbox"/> Day Treatment <input type="checkbox"/> Hospitalization <input type="checkbox"/> Out Patient Counseling <input type="checkbox"/> Residential Treatment
3	Are you currently (or within the past 1 year) taking medication(s) to treat any mental health issue? <input type="checkbox"/> YES <input type="checkbox"/> NO
4	Have you experienced any of the following significant events within the past year? <input type="checkbox"/> Serious illness <input type="checkbox"/> Self harm <input type="checkbox"/> Incarceration <input type="checkbox"/> Serious accident/injury <input type="checkbox"/> Expulsion <input type="checkbox"/> Death
5	Please arrange for a release of information with your therapist and/or prescribing physician so we may contact them for further information as part of this screening process. Have you done so? <input type="checkbox"/> YES <input type="checkbox"/> NO
6	Please provide the name and <u>telephone & fax # s</u> of your therapist and/or physician: Therapist _____ Tel # _____ Fax # _____ Physician _____ Tel # _____ Fax # _____

G. Lifestyle

#	Issue	Yes	No	Further Information
1	Do you use alcohol?			How much? How often?
2	Do you use tobacco?			How much? How often?
3	Do you use drugs (other than alcohol or prescription) on a regular basis?			Which one(s)? How often?
4	Have you been on probation or had any involvement with the Justice System?			Date(s): Reason:

H. Current Exercise Activity (It is important for us to be aware of your fitness level)

Please list the activities you engage in daily or weekly which indicate your current fitness level. Be sure to include activities such as walking a pet, mowing a lawn—or after school activities like playing basketball or skateboarding.

Activity	Frequency	Approximate Time/Distance	Leisurely	Moderately	Intensely

Note: You will be expected to engage in rigorous physical activity during your Outward Bound experience. It is vital that you start (or continue) a conditioning regimen in preparation for the program!

I. Swimming Ability (Check One)

- Non-Swimmer Cannot swim more than 100 yards Moderate Swimmer
 Strong Swimmer Current Lifesaving Certificate

Participant Comments: _____

PART III Physician's Examination Section

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:

- Backpacking w/50-60 lb. pack, hours at a time, over rough terrain
- Portaging 70 lb. canoe, ½ to several miles, across rough terrain
- Rock climbing or a ropes course—extreme heights
- Remote wilderness setting
- Immersion in cold water
- Running on uneven ground
- High altitude hiking/backpacking

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!

(Please review your patient's "Participant Confidential Medical Record" as part of this examination.)

A. Vital Signs/Statistics Information must be based upon examination done within one year of course start date

Patient's Name _____ Height _____ Weight _____ IF applicable, please indicate by how many lbs. patient is over or underweight: Overweight by _____ lbs. Underweight by _____ lbs. Pulse Irregularities <input type="checkbox"/> No <input type="checkbox"/> Yes IF yes, please describe symptoms and indicate clinical significance: _____	Blood Pressure _____ / _____ IF BP is over 150/90, please repeat: Second Reading _____ / _____ Date Taken _____
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B. Physician's Examination Information must be based upon examination done within one year of course start date

√ if normal		Describe if abnormal		√ if normal		Describe if abnormal	
Eyes				Hernia			
Ears				Genitals			
Nose				Back			
Throat/Mouth				CNS			
Neck				Lymph Nodes			
Thyroid				Skin			
Thorax/Lungs				Scars			
Heart				Extremities			
Heart Murmur				Shoulders			
If Murmur -- Functional				Knees			
				Ankles			
Peripheral Vsls.				Feet			
Abdomen				Other			

C. Summary of Active Medical Problems and/or Restrictions NONE or list below

D. Pre-Acceptance Cardiovascular Testing

This program will 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)
- Smoker (smoked regularly within the past year)
- Diabetes
- Known abnormally high cholesterol level or on a diet or medication for a lipid abnormality
- Family history (parent/sibling) of heart attack, coronary artery by-pass/angioplasty, or sudden, unexplained death **before age 55**
- Current cardiovascular disease
- History of prior heart disease
- Unexplained chest pain/pressure, shortness of breath, heart palpitations, sweats or exertional dizziness or faint 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? No Yes

~ Has this patient had an exercise stress test within the past year? No Yes

~ Please forward a copy of the test summary: Enclosed Will FAX FAX to: _____

Participation in this program will depend upon interpretation of the test.

E. Immunization

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

F. Physician Recommended Referrals

Do you feel further examination or specialty referral is indicated for this patient prior to participation in this wilderness program? No Yes

Please explain: _____

Consulting Opinion: Enclosed Will FAX FAX to: _____

G. Physician's Signature

How long have you known the applicant? _____

Please print physician's name: _____

Physician's Signature _____ Date of Exam _____ / _____ / _____
Must be within 1 year of start date

Telephone # (____) _____ FAX # (____) _____ email _____