



# OUTWARD BOUND

Instructor Notes

Office Use Only

Follow-up

Approval

## Youth Confidential Medical Record Urban Program / 1-Day Center-Based

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

**INSTRUCTIONS:** All the questions on this form are important. The answers are needed in order to assess your level of participation in the program.

### PART I General Information

Group Name \_\_\_\_\_ Date \_\_\_\_\_

**APPLICANT** \_\_\_\_\_ Address \_\_\_\_\_ Apt. \_\_\_\_\_  
Gender:  Male  Female SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Age \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Tel #: Hm (\_\_\_\_\_) \_\_\_\_\_ Wk (\_\_\_\_\_) \_\_\_\_\_  
Do you speak/understand English? Yes  No  Cell (\_\_\_\_\_) \_\_\_\_\_ email \_\_\_\_\_

**PARENT/GUARDIAN**  
Name \_\_\_\_\_  
Tele #s Hm (\_\_\_\_\_) \_\_\_\_\_ Wk (\_\_\_\_\_) \_\_\_\_\_  
Cell (\_\_\_\_\_) \_\_\_\_\_ email \_\_\_\_\_

**EMERGENCY CONTACT (if parent not available)**  
Name/Relationship \_\_\_\_\_  
Tele #s Hm (\_\_\_\_\_) \_\_\_\_\_ Wk (\_\_\_\_\_) \_\_\_\_\_  
Cell (\_\_\_\_\_) \_\_\_\_\_ email \_\_\_\_\_

**ETHNIC BACKGROUND (Optional)**  Choose Not to Answer  
 Asian  Caucasian (Non-Hispanic)  American Indian/Alaskan Native  
 Multi-Ethnic  Native Hawaiian or Pacific Island  Do Not Know Ethnicity  
 Hispanic/Latino  African American  Other \_\_\_\_\_

**INSURANCE INFORMATION** Do You Have Insurance? Yes  No   
Insurance Company \_\_\_\_\_ Policy/Certificate # \_\_\_\_\_ Telephone # (\_\_\_\_\_) \_\_\_\_\_

### PART II Medical Information

Height \_\_\_\_\_ feet \_\_\_\_\_ inches Weight \_\_\_\_\_ lbs.

**A. Serious Medical Conditions** Please  $\checkmark$  any of the following that apply:

Heart Disease or heart problem (other than "normal heart murmur" that doesn't require medication and/or restrictions to activity)  
 Blood Disorder such as Anemia or Sickle Cell Trait  Head injury in the past year in which you lost consciousness  
 Asthma  Seizure Disorder/Seizure w/in the past year  Insulin-Dependent Diabetes  Other \_\_\_\_\_  
**Please explain:** \_\_\_\_\_

**B. Conditions That May Be Affected By Program Activities** Please  $\checkmark$  any of the following that apply:

Use of medical device e.g., artificial limb/prosthetic device  Currently Pregnant  Food  
**Please explain:** \_\_\_\_\_

**Please list any allergies you have to: Food(s), Medication(s), Insect Bite/Bee Sting, Environment (grass, pollen):**

Allergy to: \_\_\_\_\_ What happens? \_\_\_\_\_ How do you treat it? \_\_\_\_\_  
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**C. Counseling** Please  $\checkmark$  any of the following that apply:

**Are you in counseling now or have you been within the past 1 year?**  Yes  No  
**Have you experienced or been diagnosed with any of the following:**  
 Suicide  Eating Disorder  Violent Behavior  Schizophrenia  Bipolar Disorder  Anxiety  Major Depression

**D. Medications** Please include psychiatric medication, over the counter medication, inhalers, and herbal supplements

Medication: \_\_\_\_\_ For how long? \_\_\_\_\_ Medication: \_\_\_\_\_ For how long? \_\_\_\_\_  
Medication: \_\_\_\_\_ For how long? \_\_\_\_\_ Medication: \_\_\_\_\_ For how long? \_\_\_\_\_

### PART III Signature

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 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 participants.

\_\_\_\_\_  
Parent's/Guardian's Signature (if applicant is under legal age) \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_  
Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_