



OUTWARD BOUND

Instructor Notes

Office Use Only

Follow-up

Approval

Youth 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

INSTRUCTIONS

All the questions on this form are important. The answers are needed in order to assess your level of participation in the program. Please answer every question in every section and return the form as soon as possible, in order to allow time for any needed follow-up. Incomplete forms will slow down the screening process, and may cause you to miss out on your Outward Bound program.

PART I General Information

Group Name _____ Date _____

APPLICANT	
Name _____	Daytime Telephone (____) _____
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Evening Telephone (____) _____
Age _____ DOB ____/____/____ SS# _____ - _____ - _____	FAX (____) _____ Cell Phone (____) _____
Address _____ Apt. _____	email _____
City/State/Zip _____	Do you speak/understand English? Yes <input type="checkbox"/> No <input type="checkbox"/>
PARENT/GUARDIAN	EMERGENCY CONTACT (other than parent/guardian)
Name _____	Name/Relationship _____
Home Telephone (____) _____	Daytime Telephone # (____) _____
Work Phone (____) _____ FAX (____) _____	Evening Telephone # (____) _____
Cell Phone (____) _____ email _____	Cell Phone # (____) _____ email _____
FAMILY PHYSICIAN	
Name _____ Telephone # (____) _____ FAX # (____) _____	
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 answer the following questions for our insurance records (Please attach a photocopy of both the front and back of your insurance card)	
DO YOU HAVE INSURANCE? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Insurance Company _____	Policy/Certificate # _____
Prescription Plan # _____	Telephone # (____) _____

PART II Medical Information

A. Allergies (Including allergies to medicines, foods, insect bites/stings) NONE or...

Allergy	Reaction	Medication Required (if any)

B. Current Medications (Including psychiatric, over the counter, inhalers, herbal supplements) NONE or...

Medication	Taken For: (Symptom/Condition)	Dosage	Date Started	Current Side Effects

Outward Bound recommends that all of its participants have a current tetanus immunization (within 10 years).

PART III Health Profile

#	Please <input checked="" type="checkbox"/> one--If yes, describe below	Y	N	#	Please <input checked="" type="checkbox"/> one--If yes, describe below	Y	N
1	Seizure within the past 1 year			6	Use of Tobacco/Smoker		
2	Hospitalization/Emergency Room/Urgent Care visit within the past 1 year			7	Current Neck/Back/Shoulder/Knee/Ankle/or other joint problem		
3	Asthma (If yes, please bring inhaler)			8	Currently Pregnant		
4	Unexplained chest pain/pressure, shortness of breath, rapid heartbeat, sweats, or exertional dizziness or faint spells			9	Bedwetting		
				10	Diagnosed Learning Disability and/or ADD/ADHD		
5	Other cardiac conditions, e.g., heart murmur or other rhythm abnormality			11	Other medical issues/illnesses/symptoms/requirements/prosthetic device(s)		
#	Describe						
#	Describe						

PART IV Cardiovascular Fitness Evaluation REQUIRED INFORMATION

A. Important! Background Information (We need this information to evaluate you for participation in your program)

Blood Pressure must be taken within 6 months of course start. You may take your own blood pressure using apparatus at local department or drug store.	Age _____ Height _____ ft. _____ ins. Weight _____ lbs. Blood Pressure Reading _____ / _____ Date Taken _____ IF BP is over 150/90, please take a second time: Second BP Reading _____ / _____ Date Taken _____
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B. Current Exercise Activity (It is important for us to be aware of your fitness level)

Please list the activities you do on a daily or weekly basis which show your current fitness level. Be sure to include activities such as walking a pet, mowing a lawn--or after school activities such as playing basketball, skateboarding, skiing, etc.

Activity	Frequency	Approximate Time/Distance	Leisurely	Moderately	Intensely

C. Personal History

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 the above 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 # _____

PART V Signature Required

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