MEDICAL RECORD

/ 2C: B

North Carolina Outward Bound School

Welcome to Outward Bound!

All participants are required to complete our Medical Record booklet. The information you provide informs us of your physical, emotional and motivational ability to attend course and helps determine if an Outward Bound course is appropriate for you at this time.

Take time to answer our questions completely. Every item in the Medical Record booklet must be completed. Mark a section "N/A" if it is not applicable to you. Any item or section not completed will require telephone or written follow-up. Failure to fully complete required forms will delay your application. Keep a copy of this booklet for your records.

It is imperative that you or your doctor notify our Medical Screener of any significant changes in your health after you submit the Medical Record booklet and prior to your course start.

We have a policy of accepting participants who are physically challenged or have special medical conditions providing their condition does not pose a significant safety risk to themselves or others. This long-standing policy is consistent with our educational goals and philosophies as well as our legal and ethical obligations.

MEDICATIONS

Participants requiring prescription medications must bring **double** their normal dosage due to the potential of loss or damage of a medication. If you are unable to meet this requirement due to FDA/DEA restrictions on the medication or medication costs, please notify our Medical Screener.

Non-prescription or prescription drugs brought on course must be noted in the Medical Record booklet. Medications listed must accompany the participant on course.

Participants will not be permitted to begin their course without their required medications OR with new medications not approved by our Medical Screener.

Non-prescription drugs and prescription drugs not listed on the approved Medical Record booklet are not permitted on North Carolina Outward Bound courses.

NUTRITION

Outward Bound practices Leave No Trace camping ethics. Therefore, we seldom build fires. You will be cooking on gas camp stoves. Your instructors will teach you how to use the stoves and you will be responsible for helping with the preparation of all meals for yourself and your crewmates. While on course, you will be eating foods that travel well, are light-weight and portable. The food is wholesome, nutritious and selected to meet the high energy demands of the program. We use a lot of hummus, bagels, beans, rice, tortillas, pita bread, peanut butter, jelly, tuna fish, pasta and trail mixes. The amount of physical activity you experience during your course demands a nutritious diet to help fuel your body. Therefore, junk food is not available on course. To prepare, we suggest you cut down on candy, soft drinks, coffee, pastries and other junk foods. Moderating caffeine, alcohol and tobacco consumption will contribute to your fitness. These products will not be part of your Outward Bound course; a clear head and fast reflexes are essential to safety and success on course.

If you are overweight, don't go on a crash diet to shed extra pounds; you will only deplete the strength you want to develop. Please check with our Medical Screener to set a realistic goal for weight loss and stay committed. With advance notice, lactose-free and vegetarian diets can be accommodated. For other diets, such as low fat, vegan and lactose-free vegetarian, it may be necessary for you to bring supplements. Talk with our Medical Screener about appropriate foods and amounts.

North Carolina Outward Bound - Student Services Department - 2582 Riceville Road, Asheville, NC 28805
800-878-5258 - FAX 828-298-8660 - studentservices@ncobs.org

ADDITIONAL FORMS

Depending on your course and the answers received during your medical pre-screen, you may need to fill out additional forms to complete your application process. These additional forms will be indicated in your **Registration E-mail or Letter** and should be returned along with this Medical Record booklet, pages 4-6 of the Policy Booklet and the Participant Acknowledgement and Assumption of Risks and Liability Release and Indemnity Agreement.

INSURANCE

During your course, you should be covered by your own or your family's health and/or accident insurance. Please provide your policy number, company name and address and the policy holder's name. Bills for medical treatment will be the responsibility of your insurance company.

You must copy both the front and back of your health insurance card and attach these copies to the specified page of this Medical Record booklet.

If you are not covered by health and/or accident insurance, you or your family are responsible for any costs incurred. We suggest you consider purchasing a short-term health insurance plan. For our international courses or courses with an international component, we also suggest you consider purchasing travel insurance.

INFORMATION ON COMPLETING AND RETURNING YOUR FORMS

Directions for completing your forms can be found by clicking this link: Complete Your Forms.

QUESTIONS

If you have questions regarding the Medical Record booklet, contact our Medical Screener at 800-709-6098 or e-mail medical@ncobs.org.

Other non-related medical questions should be directed to your Student Services Representative at 800-878-5258 or e-mail studentservices@ncobs.org.

RETURN

OUTWARD BOUND

Instructor Notes

Office Use Only

Follow-up/Approval

Participant Confidential Medical Record

This form may be filled in **on-line** and signed with a digital signature option. Or you may print out this form and fill it in using **blue or black ink**.

PART I General Information

Program/Course ____________ **Starting Date** ________

Applicant

Name ______________________________________

Address ______________________________________

City/State/Zip ______________________________________

Home Telephone ______________________________________

Cell ______________________________________

Email ______________________________________

Gender ☐ Male ☐ Female

Age at Program Start _______ DOB _____/_____/_____

Height__________ft.___________inches

Weight _________lbs.

BLOOD PRESSURE - Taken within 6 months of course start

Blood Pressure ______________/______________

Date Taken ______________________________

Blood pressure may be taken with apparatus at a local grocery or drug store.

Parent/Custodial Guardian (if applicant is under the age of 21)

Name ______________________________ Email ______________________________

Relationship ______________________________ Occupation ______________________________

Address ______________________________ City/State/Zip ______________________________

Preferred Telephone #1 ______________________ Preferred Telephone #2 ______________________

Other Parent/Custodial Guardian (if applicant is under the age of 21)

Name ______________________________ Email ______________________________

Relationship ______________________________ Occupation ______________________________

Address ______________________________ City/State/Zip ______________________________

Preferred Telephone #1 ______________________ Preferred Telephone #2 ______________________

Emergency Contact (not parent/guardian)

Name ______________________________ Relationship ______________________________

Preferred Telephone #1 ______________________ Preferred Telephone #2 ______________________

Ethnic Background (Optional)

☐ Asian ☐ Caucasian (Non-Hispanic) ☐ American Indian/Alaskan Native

☐ Multi-Ethnic ☐ Native Hawaiian or Pacific Island ☐ Do Not Know Ethnicity

☐ Hispanic or Latino ☐ African American ☐ Other ______________________

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 (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. 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. 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.** If you (or your child) arrive at the program start with a pre-existing 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 may not receive a refund of tuition.

____ ______________

Applicant's Signature Date

____ ______________

Parent's/Guardian's Signature Date

(Required if applicant is under 21 years of age)

PART II Participant History: Past and Present Medical Problems

A. If you answer "yes" to any of the items, please explain below. Include the following:

- Specific symptoms that are occurring
- How long symptom/condition lasts
- Date of last occurrence
- How often symptom/condition occurs
- How you care for symptom/condition
- Any restrictions

#	Condition	Y	N	Detailed Description (including restrictions, if any)
1	High Blood Pressure	☐	☐	
2	Heart Disease	☐	☐	
3	Heart Murmur	☐	☐	
4	Irregular Heartbeat / Palpitations	☐	☐	
5	Family history of heart attack	☐	☐	
6	Chest Pain / Pressure	☐	☐	
7	Circulation Problems	☐	☐	
8	Frostbite	☐	☐	
9	Heatstroke	☐	☐	
10	Frequent Dizziness / Fainting	☐	☐	
11	History of Altitude Sickness	☐	☐	
12	Headaches / Migraines	☐	☐	
13	Head injury with neurological impairment	☐	☐	
14	Tuberculosis / Positive TB test	☐	☐	
15	Asthma or COPD	☐	☐	
16	Active or History of Hepatitis	☐	☐	
17	Lyme Disease	☐	☐	
18	Seizure Disorder / Epilepsy	☐	☐	
19	Seizure within past 6 months	☐	☐	
20	Bleeding / Blood Disorder	☐	☐	
21	Sickle Cell Anemia	☐	☐	
22	Sickle Cell Trait	☐	☐	
23	Hypoglycemia (low blood sugar)	☐	☐	
24	Diabetes	☐	☐	
25	Cancer	☐	☐	
26	Thyroid Problems	☐	☐	
27	Gastro-intestinal Problems	☐	☐	
28	Special Diet	☐	☐	
29	Food Allergies	☐	☐	
30	Kidney Problems	☐	☐	
31	Urinary Tract Problems	☐	☐	
32	Bedwetting	☐	☐	
33	Orthopedic Problems	☐	☐	
34	Broken Bones within past year	☐	☐	
35	Hearing Impairment	☐	☐	
36	Vision Impairment	☐	☐	
37	Skin Problem	☐	☐	
38	Motion Sickness	☐	☐	
39	Sleep Walking	☐	☐	
40	PMS/Menstrual Problems (severe)	☐	☐	
41	Currently Pregnant	☐	☐	
42	Medical Equipment/ Devices	☐	☐	
43	Other	☐	☐	
44	Other	☐	☐	

B. Allergies - Including allergies to medicine, foods, insect bites/stings, environmental, etc.

☐ NONE

(Or list to right)

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.

☐ NONE

(Or list to right)

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

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, please contact Outward Bound.

D. Hospitalizations/Emergencies/Urgent Care

Please list any hospital, psychiatric, or urgent care visits within the past 1 year

☐ NONE

(Or list to right)

Date of Visit/Admittance	Reason	Length of Stay

E. Immunization

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

Personal History - Based upon past 1 year

#1 Have you been diagnosed or treated for any of the following disorders currently or within the past year?

- Y ☐ N ☐ Attention Deficit Disorder (ADD)
- Y ☐ N ☐ Adjustment Disorder
- Y ☐ N ☐ Anxiety Disorder
- Y ☐ N ☐ Disruptive Behavior Disorder
- Y ☐ N ☐ Eating Disorder
- Y ☐ N ☐ Impulse Control Disorder
- Y ☐ N ☐ Learning Disorder
- Y ☐ N ☐ Developmentally Disabled
- Y ☐ N ☐ Mood Disorder
- Y ☐ N ☐ Personality Disorder
- Y ☐ N ☐ Pervasive Developmental Disorder
- Y ☐ N ☐ Substance Related Disorder
- Y ☐ N ☐ Schizophrenia
- Y ☐ N ☐ Other ____________________

#2 Have you received treatment or therapy for any of the following, either currently or in the past year?

- Y ☐ N ☐ Medication(s)
- Y ☐ N ☐ Out Patient Counseling
- Y ☐ N ☐ Day Treatment
- Y ☐ N ☐ Psychiatric Hospitalization
- Y ☐ N ☐ Residential Treatment

#3 Have you experienced any of the following significant events within the past year? If yes, please explain

- Y ☐ N ☐ Serious illness____________________
- Y ☐ N ☐ Serious accident/injury ______________
- Y ☐ N ☐ Self harm __________________________
- Y ☐ N ☐ Expulsion __________________________
- Y ☐ N ☐ Incarceration ______________________
- Y ☐ N ☐ Death of Family/Friend ______________

#4 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? Yes ☐ No ☐

#5 Please provide the name and telephone & fax #s of your therapist and/or prescribing physician:

Therapist ______________________________ Telephone # ______________________________
Fax # ______________________________ Email ______________________________

Prescribing Physician ______________________ Telephone # ______________________________
Fax # ______________________________ Email ______________________________

F. 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 recreational drugs?			Which one(s)?	How often?
4	Have you been on probation or had any involvement with the Justice System?			Date(s): Reason:	
5	Do you have a history or current problem with substance abuse/dependency?			How long?	

G. 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 that indicate your current fitness level. Be sure to include all activities.

☐ **NONE**

(Or list to right)

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!

J. Swimming Ability (Check One)

- ☐ Non-Swimmer
- ☐ Weak Swimmer
- ☐ Moderate Swimmer
- ☐ Strong Swimmer
- ☐ Current Lifesaving Certificate

PART III APPLICANT QUESTIONNAIRE

THE ANSWERS TO THESE QUESTIONS WILL HELP YOUR INSTRUCTORS PLAN YOUR COURSE ACTIVITIES AND LEARN MORE ABOUT YOU.

1.) Why are you interested in attending Outward Bound?

2.) What are you most looking forward to while on course?

3.)What concerns, if any, do you have about your course?

4.)What do you consider helpful for your instructors to know about you?

5.) Please list three words you would use to describe yourself.

1.)
2.)
3.)

6.) What is/was your job in the military? With which units did you serve?

7.) What were your periods of deployment and in which country/province did you deploy?

8.) How do you work through emotional challenges that are a result of your deployment?

9.) How did you hear about the Outward Bound Veterans Program? (College, University, VAMC, other)

PART IV INSURANCE INFORMATION

STAPLE OR TAPE A COPY OF THE FRONT AND BACK OF YOUR HEALTH INSURANCE CARD IN THIS SPACE

IF YOU DO NOT CARRY A HEALTH INSURANCE POLICY CHECK HERE: ❐

The following information is needed for our insurance records. Each applicant is responsible for any and all medical expenses and should be covered by his/her own sickness and accident insurance.

Insurance Company Name:________________________ Policy Number:______________________________

Claim Billing Address:___________________________ City/State/Zip:______________________________

Prescription Plan Name:_________________________ Policy Number:______________________________

Claim Billing Address:___________________________ City/State/Zip:______________________________