

# CONFIDENTIAL ADULT INFORMATION

North Carolina Outward Bound School

## IMPORTANT:

- Every item in every section must be completed.
- Mark n/a if any section is not applicable to you.
- Include a photocopy (front and back) of your health insurance card.
- Keep a photocopy of this medical form.
- Complete in full and return with \$50 deposit to:

North Carolina Outward Bound School  
Attn: Alumni Department  
2582 Riceville Road  
Asheville, North Carolina 28805  
FAX to: (828) 299-3928

If you have questions regarding medical issues contact our medical screener at (800) 709-6098 or [medical@ncobs.org](mailto:medical@ncobs.org). Other questions should be directed to 877-274-3809 or [afey@ncobs.org](mailto:afey@ncobs.org).

Your position on Swap-Ya is confirmed only when all forms are completed, signed and approved by our medical screener. Only this Confidential Information Form will be accepted. If you are not medically approved for Swap-Ya, we will refund all tuition payments. We cannot refund other expenses, including travel and clothing.

## GENERAL INFORMATION

Name \_\_\_\_\_

Outward Bound course attended, year and location: \_\_\_\_\_

Have you participated in Swap-Ya before? \_\_\_\_\_ If yes, when? \_\_\_\_\_

Skills (not required!): electrical \_\_\_\_\_ plumbing \_\_\_\_\_ carpentry \_\_\_\_\_ roofing \_\_\_\_\_ trail maintenance \_\_\_\_\_  
other: \_\_\_\_\_

**Deposit** for Swap-Ya is \$50. When you have completed the Swap-Ya work week, you have the option of receiving a refund or donating your deposit to North Carolina Outward Bound to go toward base camp refurbishment costs.

**Refund Policy:** If you cancel your enrollment in Swap-Ya, our refund policy follows:

60 days or more before Swap-Ya	100%
30-59 days before Swap-Ya	75%
15-29 days before Swap-Ya	50%
14 days or less before Swap-Ya	none

Enclosed is my check for \$50 \_\_\_\_\_

Charge my MasterCard or Visa for \$50 \_\_\_\_\_

Cardholder's Name \_\_\_\_\_

Type of card      MasterCard      Visa

Card Number \_\_\_\_\_      Expiration Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Cardholder's Signature \_\_\_\_\_

### Travel Information

- I will meet you at the airport at the prescribed time
- I will be driving to the base camp directly and will arrive on \_\_\_\_\_
- I would like to carpool. Please let me know who else is coming.
- I am carpooling with \_\_\_\_\_

I will be bringing my own sleeping bag     Yes     No

# **PART I**

**FOR OFFICE USE ONLY**

**FOLLOW-UP**

**APPROVAL**

Swap-Ya Start Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_

Age at program start \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_ft \_\_\_\_ in Weight \_\_\_\_lbs

Social Security \_\_\_\_\_ Occupation \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Day Phone (\_\_\_\_) \_\_\_\_\_ Evening Phone (\_\_\_\_) \_\_\_\_\_

E-Mail address \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Family Physician \_\_\_\_\_

Physician Phone (\_\_\_\_) \_\_\_\_\_ Physician Fax (\_\_\_\_) \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Relationship \_\_\_\_\_

Day Phone (\_\_\_\_) \_\_\_\_\_

Evening Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Do you speak and understand English?

Yes  No

Ethnic Background (optional)

Asian

Hispanic

Black / African American

Native American

White / Caucasian

Other \_\_\_\_\_

## **INSURANCE INFORMATION:**

Each participant is responsible for any medical expenses and should be covered by his/her own sickness and accident insurance. (The following questions must be answered for our insurance records.)

Insurance Company Name \_\_\_\_\_ Policy Number \_\_\_\_\_

Prescription Plan Name \_\_\_\_\_ Policy Number \_\_\_\_\_

**NOTE: ATTACH A PHOTOCOPY OF BOTH THE FRONT AND BACK OF YOUR INSURANCE CARD(S).**

## **SIGNATURES 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 which might 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 course start with a pre-existing physical, psychological or emotional condition or injury which is not fully disclosed on this form, and subsequently are forced to leave the course because of that condition, you will be charged an evacuation fee payable prior to departure and will not receive a refund of tuition.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date



## B. ALLERGIES

INCLUDING ALLERGIES TO MEDICINES, FOODS, AND INSECT BITES/STINGS.

**NONE**  OR...

Allergy	Reaction	Medication Required

## C. MEDICATIONS YOU ARE CURRENTLY TAKING

LIST ANY MEDICATIONS YOU ARE USING, INCLUDING PSYCHIATRIC AND OVER THE COUNTER MEDICATIONS

**NONE**  OR...

Medication	Condition	Dosage	Date Started	Side Effect

**NOTE:** If you are taking medication(s), bring double amounts in separate, non-breakable, waterproof containers along with dosage instructions.

**ALL MEDICATION LISTED MUST ACCOMPANY STUDENT ON COURSE!**

## D. REQUIRED IMMUNIZATION - TETANUS

Must be within ten (10) years of your Outward Bound start date

## E. HOSPITALIZATIONS/EMERGENCIES/URGENT CARE

PLEASE LIST ANY HOSPITAL, EMERGENCY DEPARTMENT, OR URGENT CARE CENTER VISITS IN THE LAST TWO YEARS.

**NONE**  OR...

Date of Visit/Admittance	Reason	Length of Stay

## F. PERSONAL HISTORY

Have you been in counseling with a psychiatrist, psychologist, guidance counselor, or other counselor within the past two years?..... Yes  No

Are you currently in counseling with a counselor psychiatrist, psychologist, or prescribing physician?..... Yes  No

Please arrange for a release of information with your counselor and/or prescribing physician so we may contact him/her. Have you done so?..... Yes  No

Reason for counseling (check appropriate responses)

- Academic     Family Issues     Depression     Eating Disorder     Substance Abuse  
 Career     Divorce     Suicide     Medication Maintenance     Other \_\_\_\_\_

Name of current or most recent counselor \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_ E-Mail \_\_\_\_\_

Name of prescribing physician \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_ E-Mail \_\_\_\_\_

## G. LIFE-STYLE

Do you use alcohol?                      Yes  No     How much? \_\_\_\_\_ How often? \_\_\_\_\_

Do you use tobacco,  
or tobacco products?                      Yes  No     How much? \_\_\_\_\_ How often? \_\_\_\_\_

Do you currently have a substance  
abuse problem (alcohol, drugs, etc.)?    Yes  No     If yes, please describe \_\_\_\_\_

Do you have a history of chemical  
dependency?                                  Yes  No     Drug(s) \_\_\_\_\_ Last used? \_\_\_\_\_

## H. SWIMMING ABILITY

(check one)

- Non-Swimmer                                   Cannot swim more than 100 yards                                   Moderate Swimmer  
 Strong Swimmer                                   Current lifesaving certificate

## I. BLOOD PRESSURE

**(MUST BE TAKEN WITHIN SIX (6) MONTHS OF COURSE START)**

Blood Pressure \_\_\_\_\_/\_\_\_\_\_

If BP is over 150/90, please repeat

Date taken \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Second Reading \_\_\_\_\_/\_\_\_\_\_

NOTE: Blood pressure may be taken with apparatus at a local department or drug store.

# ACKNOWLEDGMENT OF RISK & ASSUMPTION OF PERSONAL RESPONSIBILITY

I understand that during my participation in the North Carolina Outward Bound Swap-Ya program, I might be exposed to inclement weather and above normal risks.

I understand that although North Carolina Outward Bound has taken precautions to provide proper organization, supervision, instruction and equipment, it is impossible for North Carolina Outward Bound to guarantee absolute safety. Also, I understand that I share the responsibility for safety during the program and I assume that responsibility. I agree to comply with the instructions and directions of North Carolina Outward Bound staff members during the program.

I have accepted responsibility to verify with my physician that I have no physical or psychological problems that would prohibit my participation in the program.

Name \_\_\_\_\_  
*(please print)* Signature\_\_\_\_\_

## PHOTO CONSENT

I hereby authorize and give full consent to North Carolina Outward Bound to copyright or publish all photographs in which I, *(print name)* \_\_\_\_\_, appear while enrolled as a student in any and all of its programs. I further agree that North Carolina Outward Bound may transfer, use or cause to be used these photographs for any and all exhibitions, public displays, publications, commercials, art and advertising purposes without limitation or reservation.

Signature \_\_\_\_\_ Date\_\_\_\_\_

North Carolina Outward Bound often sends written press releases to magazines and newspapers around the country. We need your permission to give your name to local media as an Outward Bound participant. If you will allow North Carolina Outward Bound to do so, please complete the following:

My hometown newspaper is:\_\_\_\_\_

Permission is hereby granted to use my name in press releases: Yes\_\_\_\_\_ No\_\_\_\_\_