OUTWARD BOUND

RETURN

FOLLOW-UP

2 PAGE YOUTH MEDICAL RECORD

OFFICE USE ONLY

APPROVAL

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 this form as soon as possible, in order to allow time for any follow-up. Insurance Information: If you have insurance, please attach a photocopy of the front and back of your insurance card. ***Each participant is responsible for any medical expenses and should be covered by your own illness and accident insurance***.

PART I – GENERAL INFORMATION

PROGRAM/COURSE NUMBER _____START DATE _____

APPLICANT

Name: _____ Title: ☐Dr. ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Other _____

Address: _____ Age at Start: _____ Date of Birth: _____

City/State/Zip: _____ Height: _____ ft. _____ in. Weight:_____lbs.

Home Phone: _____ Sex: ☐Male ☐Female ☐Intersex

Cell Phone: _____ Gender: ☐Male ☐Female ☐Non-Binary ☐Transgender

E-mail: _____ Occupation: _____

Parent/Custodial Guardian

Name: _____ Title: ☐Dr. ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Other ____

Address: _____ Relationship to Applicant: _____

City/State/Zip: _____ Occupation: _____

Cell Phone: _____ Work Phone: _____

E-mail: _____ Home Phone:_____

Emergency Contact (other than parent/guardian)

Name: _____ Relationship to Applicant: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Work Phone: _____

Ethnicity (optional)

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

☐ Multi-Ethnic ☐ Native Hawaiian or Pacific Islander ☐ Unknown

☐ Hispanic or Latino ☐ African American ☐ Other: _____

PART II – MEDICAL INFORMATION

A. ALLERGIES Include allergies to medicine, foods, insect bites/stings, environmental, etc.

Allergy (List Below)	**Reaction** (List Below)	**Medication Required** (If Any)

B. 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.

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

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 prior to course must be shared with Outward Bound as soon as possible.*

PART III – HEALTH PROFILE If any apply, check the box and provide details on the space below.

- ☐ Asthma (if yes, bring inhaler)
- ☐ Bedwetting
- ☐ Cardiac Conditions, e.g., Heart Murmur or other rhythm abnormality
- ☐ Current Orthopedic Problems (neck/back/knee/shoulder)
- ☐ Currently Pregnant
- ☐ Special Diet
- ☐ Hospitalization/Emergency Room visit within past year
- ☐ Seizure within the past 6 months
- ☐ Unexplained chest pain/pressure, shortness of breath, heart palpitations, sweats/exertional dizziness/fainting spells
- ☐ Use of tobacco
- ☐ Other medical issues, illnesses, symptoms, requirements or prosthetic device(s)

Describe: _____

Describe: _____

Blood Pressure: _____ Date Taken: _____ (Must be within 1 year of course start)
Blood pressure may be taken with apparatus at a local grocery or drug store.

CURRENT PHYSICAL ACTIVITY List your current physical activity (if any). You will be expected to engage in rigorous physical activity during your Outward Bound experience. It is vital that you start (or continue) a physical fitness routine in preparation for the program.

Activity	Frequency	Time/Distance	Leisurely	Moderately	Intensely

PART IV – PSYCHIATRIC AND MENTAL HEALTH HISTORY Within the past year. If any apply, check the box and provide details on the space below.

- ☐ ADHD
- ☐ Anxiety Disorder
- ☐ Depressive Disorder
- ☐ Eating Disorder
- ☐ Learning Disability
- ☐ Personality Disorder
- ☐ Substance Related Disorder
- ☐ Other: _____
- ☐ Autism Spectrum Disorder
- ☐ Bipolar Disorder
- ☐ Disruptive and Conduct Disorder
- ☐ Intellectual Disability
- ☐ Obsessive Compulsive Disorder
- ☐ Schizophrenia Spectrum Disorder
- ☐ Trauma and Stressor Related Disorder

Describe: _____

Have you received treatment or therapy for any of the above, either currently or in the past year? If YES, check the box and provide details on the space below.

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

Describe: _____

If you checked any of the above, please provide the following information for your therapist and/or prescribing physician:

Prescribing Physician Name: _____
Phone Number: _____
Fax Number: _____
Email: _____

Therapist Name: _____
Phone Number: _____
Fax Number: _____
Email: _____

PART V - SIGNATURE REQUIRED

All information will remain confidential except that information may be disclosed to a medical provider as needed for my care. Over the year, many participants with a variety of medical/psychological difficulties have successfully completed our programs, but we must be aware of these conditions. **Failure to disclose medical information could result in serious harm to you and your fellow participants**. I understand that I may be in an area where communication, transportation, or evacuation is subject to delay. I will be attending an Outward Bound program and I give permission for any emergency anesthesia, operation, hospitalization or other treatment that may become necessary. I agree to be responsible for any and all charges associated with such treatment.

Applicant's Signature: _____ Date _____

Parent's/Guardian's Signature: _____ Date _____

(Required if applicant is under the age of 18 OR if applicant is a resident of Alabama and is under the age of 19 OR if applicant is a resident of Mississippi and is under the age of 21.)