



Instructor Notes	
Office Use Only	Follow-up
	Approval

Adult Confidential Medical Record

Complete as directed and return to:

Baltimore Chesapeake Bay OB Center
1900 Eagle Drive
Gwynns Falls/Leakin Park
Baltimore, MD 21207

Phone: (410) 448-1721 X 1105
FAX: (410) 298-3822
cborst@outwardbound.org

INSTRUCTIONS

Please fully complete and return this form as soon as possible in order to allow us adequate time for review and possible follow-up questions. We will determine the status of your participation after review of this form. We may require further evaluation by a physician in order for you to fully participate. If you choose to not proceed with the recommended follow-up, you may have the option of limited participation (based on our assessment of your medical constraints). Please return the form, regardless of what choice you make. Please write legibly in blue or black ink.

NOTE: Most of our programs are structured to accommodate various levels of participation. Regardless of your participation status, you will be able to be fully interactive with your group during most of the program activities. If you arrive at the program without a pre-reviewed medical record, your status will be as OBSERVER, only.

PART I **General Information** **Program/Course** **Date** _____

APPLICANT	
Name _____	Daytime Telephone _____
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Evening Telephone _____
Age _____ DOB ____/____/____	FAX _____ Cell _____
Address _____ Apt. _____	email _____
City/State/Zip _____	Do you speak/understand English? Yes <input type="checkbox"/> No <input type="checkbox"/>
EMERGENCY CONTACT	PHYSICIAN
Name _____	Name _____
Relationship _____	Telephone _____
Daytime Telephone _____	FAX _____
Evening Telephone _____	email _____
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"/> American Indian/Alaskan Native
	<input type="checkbox"/> Do Not Know Ethnicity
	<input type="checkbox"/> Other _____
INSURANCE INFORMATION: <i>Each participant is responsible for any medical expenses and should be covered by his/her own illness and accident insurance.</i>	
DO YOU HAVE INSURANCE? Yes <input type="checkbox"/> No <input type="checkbox"/>	
IF YOU HAVE INSURANCE, PLEASE ATTACH A PHOTOCOPY OF BOTH THE FRONT AND BACK OF YOUR INSURANCE CARD.	

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

PART III Health Profile – Please ✓ an answer for each question below.

#	If yes, describe below	Y	N	#	If yes, describe below	Y	N
1.	Seizure within the past 1 year			5.	Medical Device, e.g., hearing aid/prosthetic device		
2.	Hospitalization/Emergency Room/Urgent Care visit within the past 1 year			6.	Neck/Back/Shoulder/Knee /Ankle or other orthopedic problem		
3.	History heart attack, by-pass/angioplasty/angina			7.	Currently Pregnant		
4.	Other cardiac conditions, e.g., heart murmur or other rhythm abnormality			8.	Other medical issues/illnesses/symptoms/ requirements		
#	Describe						
#	Describe						

PART IV Cardiovascular Fitness Evaluation REQUIRED INFORMATION

A. Statistics/Vital Signs - We will be unable to evaluate you for participation in this program without this information. Please answer all questions, failure to do so will delay your enrollment process.

<p>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.)</p>	<p>Age _____ Height _____ft. _____ins. Weight _____lbs. Blood Pressure Reading _____/_____ Date Taken _____ IF BP is over 150/90, please take a second reading: Second BP Reading _____/_____ Date Taken _____</p>
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B. Cardiovascular Risk Factors – Please ✓ an answer for each question below.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Diagnosed high blood pressure, even if being controlled with medication (150/90 or higher in either case)
<input type="checkbox"/>	<input type="checkbox"/>	Have you smoked regularly within the past year?
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Known abnormally high cholesterol level or on a diet or medication for a lipid abnormality
<input type="checkbox"/>	<input type="checkbox"/>	Family history (parent/sibling) of heart attack, coronary artery by-pass/angioplasty, or sudden, unexplained death before age 55
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained chest pain/pressure, shortness of breath, heart palpitations, sweats/exertional dizziness/faint spells

C. 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 which indicate your current fitness level. Be sure to include activities such as walking a pet, mowing your lawn— or activities such as playing basketball, swimming, skiing, etc.

Activity	Frequency	Approximate Time/Distance	Leisurely	Moderately	Intensely

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

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 years, 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