



Instructor Notes

Office Use Only

Follow-up

Approval

Participant/Physician 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

Pages 1 - 4 to be completed by the applicant or parent/guardian (if applicant is under the age of 18) and provided to the examining MD, DO, CRNP, or PA. Please write legibly in blue or black ink.

PART I General Information Program/Course _____ Starting Date _____

Applicant	
Name _____	Address _____
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	City/State/Zip _____
Age at Program Start _____ DOB ____/____/____	Daytime Telephone _____
Height _____ ft. _____ ins.	Evening Telephone _____
Weight _____ lbs.	FAX _____ Cell _____
Occupation _____	email _____

Parent/Guardian (if applicant is under the age of 18)	Parent/Guardian (if applicant is under the age of 18)
Name _____	Name _____
Relationship _____	Relationship _____
Address _____	Address _____
City/State/Zip _____	City/State/Zip _____
Occupation _____	Occupation _____
Home Telephone _____	Home Telephone _____
Work Phone _____ Cell _____	Work Phone _____ Cell _____
FAX #/email _____	FAX #/email _____

Emergency Contact (not parent/guardian)

Name _____

Relationship _____

Daytime Telephone # _____

Evening Telephone # _____

Cell Phone # _____

Family Physician

Name _____

Telephone # _____

FAX # _____

Do you speak/understand English?

Yes No

Ethnic Background (Optional)

<input type="checkbox"/> Asian	<input type="checkbox"/> Caucasian (Non-Hispanic)	<input type="checkbox"/> American Indian/Alaskan Native
<input type="checkbox"/> Multi-Ethnic	<input type="checkbox"/> Native Hawaiian or Pacific Island	<input type="checkbox"/> Do Not Know Ethnicity
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> African American	<input type="checkbox"/> Other _____

Insurance Information *Each participant is responsible for any medical expenses and should be covered by his/her own illness and accident insurance*

DO YOU HAVE INSURANCE? Yes No

IF YOU HAVE INSURANCE, PLEASE ATTACH A PHOTOCOPY OF BOTH THE FRONT AND BACK OF YOUR INSURANCE CARD.

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 18 years of age, OR if applicant is from Alabama or Nebraska and under 19 years of age.)

B. Allergies - Including allergies to medicines, foods, insect bites/stings

NONE OR...

Allergy List Below	Reaction	Medication Required (if any)

C. Medications You Are Currently Taking

If psychiatric medication, please list any taken within the past 2 months

NONE or... list any you are using including psychiatric, over-the-counter, inhalers, herbal supplements

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

NOTE: If you are currently taking a medication, bring double amounts in separate original prescription bottles. All medications listed must accompany participant to the program. Any changes to the above noted medications or dosages, please contact Outward Bound.

D. Immunization

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

E. Hospitalizations/Emergencies/Urgent Care

NONE or... please list any hospital, emergency department, or urgent care visits within the past 2 years

Date of Visit/Admittance	Reason	Length of Stay

PART III Physician's Examination Section

To the Physician, Licensed Nurse Practitioner, or Physician's Assistant:

You are being asked to consult on this applicant because we want them to have a safe and healthy experience. These courses contain elements of significant physical stress requiring more strength and endurance than most individuals ordinarily encounter. Your patient may be involved in activities such as:

- Backpacking w/50-60 lb. pack, hours at a time, over rough terrain
- Portaging 70 lb. canoe, 1/2 to several miles, across rough terrain
- Rock climbing or a ropes course—extreme heights
- Remote wilderness setting
- Immersion in cold water
- Running on uneven ground
- High altitude hiking/backpacking

We have found that people who are in overall good health with average physical ability can successfully complete the program. However, because the programs often take the participants to remote areas where quick access to medical facilities may be delayed for 8 hours or longer, prevention of serious health hazards becomes paramount. We appreciate your help—your assessment of this patient and our knowledge of the course elements will allow us to make an accurate medical screening decision. Thank you!

(Please review your patient's "Participant Confidential Medical Record" as part of this examination.)

A. Vital Signs/Statistics Information must be based upon examination done within one year of course start date

Patient's Name _____ Height _____ Weight _____ IF applicable, please indicate by how many lbs. patient is over <u>or</u> underweight: Overweight by _____ lbs. Underweight by _____ lbs. Pulse Irregularities <input type="checkbox"/> No <input type="checkbox"/> Yes IF yes, please describe symptoms and indicate clinical significance: _____	Blood Pressure _____ / _____ IF BP is over 150/90, please repeat: Second Reading _____ / _____ Date Taken _____
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B. Physician's Examination Information must be based upon examination done within one year of course start date

√ if normal		Describe if abnormal		√ if normal		Describe if abnormal	
Eyes				Hernia			
Ears				Genitals			
Nose				Back			
Throat/Mouth				CNS			
Neck				Lymph Nodes			
Thyroid				Skin			
Thorax/Lungs				Scars			
Heart				Extremities			
Heart Murmur				Shoulders			
If Murmur -- Functional				Knees			
Peripheral VsIs.				Ankles			
Abdomen				Feet			
				Other			

C. Summary of Active Medical Problems and/or Restrictions **NONE** or list below

D. Pre-Acceptance Cardiovascular Testing

*This program will include a **high ropes** course and/or **rock climbing**, or other **similar activities**. Because these activities can cause both physical stress and anxiety, cardiovascular response may produce an unusually high pulse rate. If this patient is **over 40**, **has a sedentary lifestyle**, **is significantly overweight**, and/or **has any of the following cardiovascular risk factors**, we may suggest (and in some cases, **require**) that further cardiovascular testing be done prior to participation in the program.*

- Diagnosed high blood pressure, even if being controlled with medication (150/90 or higher in either case)
- Smoker (smoked regularly within the past year)
- Diabetes
- Known abnormally high cholesterol level or on a diet or medication for a lipid abnormality
- Family history (parent/sibling) of heart attack, coronary artery by-pass/angioplasty, or sudden, unexplained death before age 55
- Current cardiovascular disease
- History of prior heart disease
- Unexplained chest pain/pressure, shortness of breath, heart palpitations, sweats or exertional dizziness or faint spells

~ Do you think an exercise stress test may help assess this applicant's risk of a serious cardiac event during the stresses described above for this course? No Yes

~ Has this patient had an exercise stress test within the past year? No Yes

~ Please forward a copy of the test summary: Enclosed Will FAX FAX to:

Participation in this program will depend upon interpretation of the test.

E. Immunization

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

F. Physician Recommended Referrals

Do you feel further examination or specialty referral is indicated for this patient prior to participation in this wilderness program? No Yes

Please explain: _____

Consulting Opinion: Enclosed Will FAX FAX to:

G. Physician's Signature

How long have you known the applicant? _____

Please print physician's name: _____

Physician's Signature _____ Date of Exam ____/____/____
Must be within 1 year of start date

Telephone # (____) _____ FAX # (____) _____ email _____