



OUTWARD BOUND

Instructor Notes

Office Use Only

Follow-up

Approval

Youth Confidential Medical Record Urban Program / 1-Day Center-Based

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: All the questions on this form are important. The answers are needed in order to assess your level of participation in the program.

PART I General Information Program/Course _____ Date _____

APPLICANT _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female School ID# _____ Age _____ DOB ____/____/____ Do you speak/understand English? Yes <input type="checkbox"/> No <input type="checkbox"/>	Address _____ Apt. _____ City/State/Zip _____ Tel #s: Home _____ Work _____ Cell _____ email _____
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PARENT/GUARDIAN Name _____ Tel #s Home _____ Work _____ Cell _____ email _____	EMERGENCY CONTACT (if parent not available) Name/Relationship _____ Tel #s Home _____ Work _____ Cell _____ email _____
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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/Latino	<input type="checkbox"/> African American	<input type="checkbox"/> Other _____

INSURANCE INFORMATION **Do You Have Insurance?** Yes No
 IF YOU HAVE INSURANCE, PLEASE ATTACH A PHOTOCOPY OF BOTH THE FRONT AND BACK OF YOUR INSURANCE CARD.

PART II Medical Information Height _____ feet _____ inches Weight _____ lbs.

A. Serious Medical Conditions *Please \checkmark any of the following that apply and provide details and/or restrictions below:*

<input type="checkbox"/> Heart Disease or heart problem (any requiring medication or restrictions of activity)	<input type="checkbox"/> Head injury in the past year in which you lost consciousness
<input type="checkbox"/> Blood Disorder, such as Anemia or Sickle Cell Trait	<input type="checkbox"/> Insulin-Dependent Diabetes
<input type="checkbox"/> Asthma	<input type="checkbox"/> Seizure Disorder/Seizure w/in the past year
<input type="checkbox"/> Other _____	

Please explain: _____

B. Additional Medical Information *Please \checkmark any of the following that apply and provide details and/or restrictions below:*

<input type="checkbox"/> Use of medical device e.g., artificial limb/prosthetic device	<input type="checkbox"/> Currently Pregnant	<input type="checkbox"/> Food
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Please explain: _____

Please list any allergies you have to: Food(s), Medication(s), Insect Bite/Bee Sting, Environment (grass, pollen):

Allergy to: _____	Reaction _____	Medication _____
Allergy to: _____	Reaction _____	Medication _____
Allergy to: _____	Reaction _____	Medication _____

C. Counseling *Please \checkmark any of the following that apply:*

Are you in counseling now or have you been within the past 1 year? Yes No

Have you experienced or been diagnosed with any of the following:

<input type="checkbox"/> Suicide	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Violent Behavior	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Major Depression
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D. Medications *Please include psychiatric medication, over the counter medication, inhalers, and herbal supplements*

Medication: _____	Start Date _____	Medication: _____	Start Date _____
Medication: _____	Start Date _____	Medication: _____	Start Date _____

PART III Signature

All information will remain confidential except that information may be disclosed to a medical provider as needed for my (or my child's) care. 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 (or your child) and fellow participants. I (or my child) 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 18 years of age, OR if applicant is from Alabama or Nebraska and under 19 years of age.)