



Instructor Notes	
Office Use Only	Follow-up
	Approval

Youth 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

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 the form as soon as possible, in order to allow time for any needed follow-up. Incomplete forms will slow down the screening process, and may cause you to miss out on your Outward Bound program. Please write legibly in blue or black ink.

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 Phone _____
School ID# _____	email _____
Address _____ Apt. _____	Do you speak/understand English? Yes <input type="checkbox"/> No <input type="checkbox"/>
City/State/Zip _____	
PARENT/GUARDIAN	EMERGENCY CONTACT (other than parent/guardian)
Name _____	Name/Relationship _____
Home Telephone _____	Daytime Telephone _____
Work Phone _____ FAX _____	Evening Telephone _____
Cell Phone _____ email _____	Cell Phone _____ email _____
FAMILY PHYSICIAN	
Name _____ Telephone # _____	FAX # _____
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

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

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			6	Use of Tobacco/Smoker		
2	Hospitalization/Emergency Room/Urgent Care visit within the past 1 year			7	Current Neck/Back/Shoulder/Knee/Ankle/or other joint problem		
3	Asthma (If yes, please bring inhaler)			8	Currently Pregnant		
4	Unexplained chest pain/pressure, shortness of breath, rapid heartbeat, sweats, or exertional dizziness or faint spells			9	Bedwetting		
				10	Diagnosed Learning Disability and/or ADD/ADHD		
5	Other cardiac conditions, e.g., heart murmur or other rhythm abnormality			11	Other medical issues/illnesses/symptoms/requirements/prosthetic device(s)		
#	Describe						
#	Describe						

PART IV Cardiovascular Fitness Evaluation REQUIRED INFORMATION

A. Important! Background Information - We need this information to evaluate you for participation in your program

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.)	Age _____ Height _____ ft. _____ ins. Weight _____ lbs.
	Blood Pressure Reading _____ / _____ Date Taken _____
	IF BP is over 150/90, please take a second time: Second BP Reading _____ / _____ Date Taken _____

B. Current Exercise Activity - It is important for us to be aware of your fitness level

Please list the activities you do on a daily or weekly basis which show your current fitness level. Be sure to include activities such as walking a pet, mowing a lawn- or after school activities such as playing basketball, skateboarding, skiing, etc.

Activity	Frequency	Approximate Time/Distance	Leisurely	Moderately	Intensely

PART V Personal History – Based upon past one to two years

#	Counseling History (Based upon past two years)	Date of Last Session _____
1	Have you been diagnosed or treated for any of the following within the past two years? ✓ Yes or No Y <input type="checkbox"/> N <input type="checkbox"/> Attention Deficit Disorder (ADD) Y <input type="checkbox"/> N <input type="checkbox"/> Impulse Control Disorder Y <input type="checkbox"/> N <input type="checkbox"/> Pervasive Developmental Disorder Y <input type="checkbox"/> N <input type="checkbox"/> Adjustment Disorder Y <input type="checkbox"/> N <input type="checkbox"/> Learning Disorder Y <input type="checkbox"/> N <input type="checkbox"/> Schizophrenia Y <input type="checkbox"/> N <input type="checkbox"/> Anxiety Disorder Y <input type="checkbox"/> N <input type="checkbox"/> Mental Retardation Y <input type="checkbox"/> N <input type="checkbox"/> Substance Related Disorder Y <input type="checkbox"/> N <input type="checkbox"/> Disruptive Behavior Disorder Y <input type="checkbox"/> N <input type="checkbox"/> Mood Disorder Y <input type="checkbox"/> N <input type="checkbox"/> Other _____ Y <input type="checkbox"/> N <input type="checkbox"/> Eating Disorder Y <input type="checkbox"/> N <input type="checkbox"/> Personality Disorder	
2	Have you received any of the following treatment or therapy for any of the above conditions? ✓ Yes or No Y <input type="checkbox"/> N <input type="checkbox"/> Medication(s) Y <input type="checkbox"/> N <input type="checkbox"/> Day Treatment Y <input type="checkbox"/> N <input type="checkbox"/> Hospitalization Y <input type="checkbox"/> N <input type="checkbox"/> Out Patient Counseling Y <input type="checkbox"/> N <input type="checkbox"/> Residential Treatment	
3	Are you currently (or within the past 1 year) taking medication(s) for any mental health issue? Yes <input type="checkbox"/> No <input type="checkbox"/>	
4	Have you experienced any of the following significant events within the past year? ✓ Yes or No Y <input type="checkbox"/> N <input type="checkbox"/> Serious illness Y <input type="checkbox"/> N <input type="checkbox"/> Self harm Y <input type="checkbox"/> N <input type="checkbox"/> Incarceration Y <input type="checkbox"/> N <input type="checkbox"/> Serious accident/injury Y <input type="checkbox"/> N <input type="checkbox"/> Expulsion Y <input type="checkbox"/> N <input type="checkbox"/> Death of Family/Friend	
5	Please arrange for a release of information with your therapist and/or prescribing physician so we may contact them for further information as part of this screening process. Have you done so? Yes <input type="checkbox"/> No <input type="checkbox"/>	
6	Please provide the name and telephone & fax #s of your therapist and/or physician: Therapist _____ Tel # _____ Fax # _____ Physician _____ Tel # _____ Fax # _____	

PART VI 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.)