



FOLLOW-UP

APPROVAL

4 PAGE PARTICIPANT MEDICAL RECORD

OFFICE USE ONLY

PART I – GENERAL INFORMATION

PROGRAM/COURSE NUMBER _____ START DATE _____

APPLICANT

Name: _____
Address: _____
City/State/Zip: _____
Home Phone: _____
Cell Phone: _____
E-mail: _____

Title: Dr. Mr. Mrs. Ms. Miss Other _____
Age at Program Start: _____ DOB: _____
Height: _____ ft. _____ in. Weight: _____ lbs.
Sex: Male Female Intersex
Gender: Male Female Non-Binary Transgender
Occupation: _____

Parent/Custodial Guardian 1 (if applicant is under 21)

Name: _____
Title: Dr. Mr. Mrs. Ms. Miss Other _____
Relationship to Applicant: _____
Address: _____
City/State/Zip: _____
E-mail: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Occupation: _____

Parent/Custodial Guardian 2 (if applicant is under 21)

Name: _____
Title: Dr. Mr. Mrs. Ms. Miss Other _____
Relationship to Applicant: _____
Address: _____
City/State/Zip: _____
E-mail: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Occupation: _____

Emergency Contact (other than parent/guardian if the applicant is under 21)

Name: _____
Home Phone: _____
Email Address: _____

Relationship to Applicant: _____
Cell: _____
Work Phone: _____

Ethnicity (optional)

- Asian
- Multi-Ethnic
- Hispanic or Latino
- Caucasian (Non-Hispanic)
- Native Hawaiian or Pacific Islander
- African American
- American Indian/Alaskan Native
- Unknown
- Other: _____

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 preexisting 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 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.)

PART II APPLICANT MEDICAL HISTORY: PAST AND PRESENT

A. MEDICAL CONDITIONS

Do any of the following apply to you? If YES check the box next to the item and provide detail in the spaces below. Include the following:

- Specific symptoms that are occurring
- How long symptom/condition lasts
- Date of last occurrence
- How often symptom/condition occurs
- How you care for symptom/condition
- Any restrictions

| CONDITION | SYMPTOMS/RESTRICTIONS |
|--|-----------------------|
| <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Heart Disease | _____ |
| <input type="checkbox"/> Heart Murmur | _____ |
| <input type="checkbox"/> Irregular Heartbeat/Palpitations | _____ |
| <input type="checkbox"/> Chest Pain/Pressure | _____ |
| <input type="checkbox"/> Circulation Problems | _____ |
| <input type="checkbox"/> Frostbite | _____ |
| <input type="checkbox"/> Heatstroke | _____ |
| <input type="checkbox"/> Frequent Dizziness/Fainting | _____ |
| <input type="checkbox"/> History of Altitude Sickness | _____ |
| <input type="checkbox"/> Severe Headaches/Migraines | _____ |
| <input type="checkbox"/> Head Injury w/Neurological Impairment | _____ |
| <input type="checkbox"/> Tuberculosis/Positive TB test | _____ |
| <input type="checkbox"/> Asthma or COPD | _____ |
| <input type="checkbox"/> Active or History of Hepatitis | _____ |
| <input type="checkbox"/> Lyme Disease | _____ |
| <input type="checkbox"/> Seizure Disorder/Epilepsy | _____ |
| <input type="checkbox"/> Seizure within past 6 months | _____ |
| <input type="checkbox"/> Bleeding/Blood Disorder | _____ |
| <input type="checkbox"/> Sickle Cell Anemia | _____ |
| <input type="checkbox"/> Sickle Cell Trait | _____ |
| <input type="checkbox"/> Hypoglycemia (low blood sugar) | _____ |
| <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Thyroid Problems | _____ |
| <input type="checkbox"/> Gastro-intestinal Problems | _____ |
| <input type="checkbox"/> Special Diet | _____ |
| <input type="checkbox"/> Food Allergies | _____ |
| <input type="checkbox"/> Kidney Problems | _____ |
| <input type="checkbox"/> Urinary Tract Problems | _____ |
| <input type="checkbox"/> Bedwetting | _____ |
| <input type="checkbox"/> Orthopedic Problems | _____ |
| <input type="checkbox"/> Broken Bones within past year | _____ |
| <input type="checkbox"/> Hearing Impairment | _____ |
| <input type="checkbox"/> Vision Impairment | _____ |
| <input type="checkbox"/> Skin Problem | _____ |
| <input type="checkbox"/> Motion Sickness | _____ |
| <input type="checkbox"/> Sleep Walking | _____ |
| <input type="checkbox"/> PMS/Menstrual Problems (severe) | _____ |
| <input type="checkbox"/> Currently Pregnant | _____ |
| <input type="checkbox"/> Medical Equipment/Devices | _____ |
| <input type="checkbox"/> Other | _____ |

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

| Allergy List Below | Reaction List Below | Medication Required If Any |
|-----------------------|------------------------|-------------------------------|
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C. **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 |
|--------------------------|--------------------------------|--------------------------|-----------------|-------------------------|--------------------|
| | | | | | |
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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.*

D. **HOSPITALIZATIONS/EMERGENCIES** Please list any hospital, psychiatric, or urgent care visits within the past year.

| Date of Visit/Admittance | Reason | Length of Stay |
|--------------------------|--------|----------------|
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E. BLOOD PRESSURE

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.

F. IMMUNIZATIONS

We recommend that all of our participants have a current tetanus immunization (within 10 years)

PART III APPLICANT PSYCHIATRIC AND MENTAL HEALTH HISTORY

G. PSYCHIATRIC AND MENTAL HEALTH CONDITIONS Within the past year.

Do any of the following apply to you? If YES, check the box next to the item and provide details on the spaces 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 next to the item and provide detail on the spaces 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: _____ Therapist Name: _____
 Phone Number: _____ Phone Number: _____
 Fax Number: _____ Fax Number: _____
 E-mail: _____ E-mail: _____

PART IV APPLICANT PERSONAL HISTORY

H. LIFESTYLE

Do any of the following apply to you? If YES, check the box next to the item and provide details on the spaces below. Include dates, amounts, reasons, etc.

- Do you use alcohol? _____
- Do you use tobacco? _____
- Do you use recreational drugs or marijuana? _____
- Do you have a history or current problem with substance abuse or dependency? _____
- Have you been suspended or expelled from school in the past year? _____
- Have you been on probation or had any involvement with the justice system? _____

I. 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 |
|----------|-----------|---------------|-----------|------------|-----------|
| | | | | | |
| | | | | | |

J. SWIMMING ABILITY (CHECK ONE)

- Non-Swimmer
- Weak Swimmer
- Moderate Swimmer
- Strong Swimmer



Applicant Profile

RETURN

This section must be completed by the Applicant.

1. Why are you interested in attending Outward Bound?
2. Describe what you expect your course to be like.
3. What are your goals for this course?
4. What are your plans to prepare physically for the course?
5. What fears or concerns do you have about this course?
6. Outward Bound courses incorporate physical, emotional, and social challenges. You will be working as a team, decision making, and creating a community with participants from diverse backgrounds. What past experiences can you draw on to prepare for this aspect of your course?
7. Please list three words you would use to describe yourself.
8. What are your hobbies, interests or activities?
9. Is there any other information you feel would be helpful for our instructors?
10. What is your t-shirt size?



Travel Insurance

COBS strongly recommends purchasing travel insurance from a third party in order to protect you in the event of an emergency cancellation or early medical departure, as we are unable to provide refunds or credits in these cases. Travel insurance differs from company to company and from policy to policy, but it can often cover both travel costs and full or partial tuition costs in the event of medical emergencies. There are many companies that offer it, but we've seen success with Travelex Insurance (www.travelexinsurance.com). Of course there are other options and you should make sure to research your decision carefully. You are also welcome to contact our travel agent, Ruby Frederick at ruby@southlandstravel.com or 303-680-5241 for assistance with this.

Please read and initial the following after you have read and agreed to it:

_____ I have read the COBS Admissions and Cancellation Policies document and understand the application, cancellation, expulsion and early departure policies and related penalties.

_____ I understand that researching and deciding to purchase or decline travel insurance is my responsibility.

Please initial the following after you have read and agreed to each statement:

_____ (initial) The information I have provided is accurate and complete.

- I have read all of the course and COBS information
- I understand that this course may be in remote areas, several hours or days away from any medical facility or where communication, transportation, or evacuation is subject to delay.
- I understand that this course will be physically, socially, and emotionally challenging, involves living with a group of diverse participants, and should in no way be considered a vacation. I am ready to take on the challenge of the Colorado Outward Bound School.

As a student, I am willing to:

_____ (initial) Engage each day as a full participant and try my best throughout the course

- Follow all safety procedures and environmental practices as explained by my instructors
- Be a reliable team member and act respectfully towards other students and my instructors
- Live up to the expectation that I neither bring, obtain, nor use tobacco, alcohol, marijuana, or illegal drugs
- Refrain from socially exclusive behavior including sexual activity

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|---|
| <p>_____</p> <p>Applicant's Signature & Date</p> |
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