

MEDICAL FORM FOR PEOPLE WITH A DISABILITY

PLEASE COMPLETE ALL FOUR PAGES AND RETURN TO:

Outward Bound Trust of New Zealand • Level 6, 40 Panama Street • PO Box 25 274 • Wellington 6146 • NEW ZEALAND • Fax (04) 472 8059

PLEASE NOTE: Please keep a copy of this medical for your records in case it is lost in the post

IMPORTANT INFORMATION (Doctor and Participant to read before completing)

- Prospective participants will only be accepted on an Outward Bound® course with this Medical Examiner's report recommending acceptance.
- If the participant is not considered fit, the Medical Examiner should not recommend the participant be accepted.
- The Medical Examiner is requested to make a full and complete examination of the applicant and document their medical history.
- **Outward Bound courses can be both physically and emotionally demanding. Courses are for 8 days. Activities include running, swimming, rock climbing, kayaking, solo, sailing and tramping in all weather conditions.**
- Full disclosure of medical history is necessary for the participant's and others' safety.
- Medical problems will not necessarily exclude a prospective participant from a course, unless indicated, as long as the condition can be appropriately managed.
- This medical report is valid for **three** months from the date completed by a medical doctor and must be valid for the duration of the course.
- For further clarification or discussion the Outward Bound nurse can be contacted on **03 520 8538**.

This Medical must be valid from to

Section 1 must be completed by participant/carer/next of kin

Sections 2-4 must be completed by Doctor

Sections 5 & 6 contain additional information to be completed by Doctor if participant has a history of mental illness and/or asthma

ALL INFORMATION PROVIDED IS CONFIDENTIAL

SECTION 1 – PARTICIPANT DETAILS (Please print your answers neatly)

| | | | |
|--------------------------|---------------------------------|---|--------------------------|
| First name | Middle name | Surname | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | |
| Gender | Male <input type="checkbox"/> | Date of birth | Age |
| | Female <input type="checkbox"/> | <input type="text" value="DD / MM / YYYY"/> | <input type="text"/> |
| Address | Floor | Building name | |
| Unit | <input type="text"/> | <input type="text"/> | |
| Street number | Street name | Suburb | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | |
| R.D | P.O Box/Private Bag | Town/City | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | |
| State/Country | <input type="text"/> | | |
| Home phone | Work phone | Mobile | Fax |
| () <input type="text"/> | () <input type="text"/> | () <input type="text"/> | () <input type="text"/> |
| Preferred email | Alternative email | | |
| <input type="text"/> | <input type="text"/> | | |

FITNESS LEVEL (Please estimate your current fitness)

Can't walk Walk 10 minutes Yes Walk 20 minutes Yes Walk 40 minutes Yes
Can't run Jog 10 minutes Yes Jog 20 minutes Yes Jog 40 minutes Yes

Can you swim 20 metres with confidence? Yes No

Do you smoke? (Outward Bound is a smoke free organisation) Yes No

How many per day?

OFFICE USE ONLY

COURSE CODE **REGISTRATION NUMBER**

DECLARATION

- I declare that the information given in this form is true and complete to the best of my knowledge.
- I understand that if I have not disclosed all previous medical conditions or injuries, or if my medical condition changes, or if I receive an injury after signing this medical form and do not disclose this to Outward Bound before the start of the course, and these conditions or injuries limit or exclude me from the course, I will not be entitled to a refund.
- The safety and well being of participants on an Outward Bound course is the first concern of the Outward Bound Trust. However, I understand that all participants take part at their own risk and must accept personal liability for any injury.
- **I authorise Outward Bound to contact the Medical Examiner who gave this report to obtain further information that may be required.**
- I acknowledge that in accordance with the provisions of the Privacy Act 1993 the following information has been brought to my attention:
- This form collects personal information about me.
- The information is collected to evaluate my suitability to attend an Outward Bound course.
- The intended recipients of the information are those staff directly involved with my attendance at the Outward Bound School.
- The information is being collected and held by Outward Bound.
- The Privacy Act 1993 entitles me to have access to and request a correction of the information.

SIGNED

SIGN HERE

NAME

DATE

SECTION 2 – MEDICAL HISTORY *(to be completed by Doctor)*

DISABILITY Please describe the applicants disability/medical condition/diagnosis.

.....

.....

.....

Has the applicant had any of the following? If 'Yes' please write details including dates in the box at the bottom of the page.

- | | | | | |
|--|-----|--------------------------|----|--------------------------|
| 1. Asthma (If 'Yes' please complete Section 5)..... | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 2. Epilepsy (Must be seizure free for past 12 months, provide letter outlining history of epilepsy)..... | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 3. Mental Illness. (Depression, Anxiety, Phobia, Eating Disorders, Substance Abuse or other.) (If 'Yes' please complete Section 6) | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 4. Suicidal thoughts /attempts or self harming behaviours (If 'Yes' please complete Section 6)..... | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 5. Any conduct behavioural issues (ie ADHD) (If 'Yes' please complete Section 6) | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 6. Any learning difficulties. (Low IQ, dyslexia ...)..... | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 7. Any recent traumatic experiences or death of relative or friend in past 12 months | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 8. Any allergy (stings, food, medicine) (If 'Yes' include details in box at bottom of page) | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 9. Any heart conditions (Please seek approval from specialist if currently under care of one)..... | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 10. High Blood Pressure..... | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 11. Fainting attacks, blackouts..... | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 12. Migraine..... | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 13. Diabetes. (HbA1c <8.0 in last 3 months is required)..... | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 14. Hepatitis, HIV or AIDS related condition | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 15. Head Injury, concussion, unconsciousness | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 16. Backache, spinal injury, disc trouble | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 17. Any knee, ankle or joint injury..... | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 18. Any other serious illness, injury, operation or condition? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 19. Currently pregnant. If 'Yes' this excludes a student from attending..... | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

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20. Please provide details of any medications required below.

| Medication | Route e.g. oral, etc | Dosage and Frequency |
|------------|----------------------|----------------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

SECTION 3 – MEDICAL EXAMINATION *(to be completed by Doctor)*

| | | | | | |
|------------------------|---------------------------------|-----------------------------------|--------------------|---------------------------------|-----------------------------------|
| Cardiovascular system | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Abdomen | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| Current mental status | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Locomotor system | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| Hearing | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Respiratory system | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| Central nervous system | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Vision | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| Ears | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> | | | |

Height cm Weight kg Resting Heart Rate Blood Pressure /

Date of last tetanus booster *(Please give a booster if required)* DD / MM / YYYY

Please describe any abnormal findings

SECTION 4 – MEDICAL EXAMINER'S REPORT

Examiners Name Are you the applicant's regular doctor? Yes No

Address

Phone () Fax ()

As a Registered Medical Practitioner, I have read the general information on the front of this medical form and I can certify that the health and fitness of this applicant is: (please tick one)

Satisfactory – Applicant should be accepted

Not Satisfactory – Applicant should not be accepted

MEDICAL EXAMINER'S SIGNATURE DATE

SIGN HERE

DD / MM / YYYY

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SECTION 5 – ASTHMA ADDITIONAL INFORMATION *(to be completed if you answered ‘Yes’ to Medical History Question 1)*

Outward Bound runs physically and mentally demanding residential courses at our school in Anakiwa. It is important to note that there is a wide range of conditions that individuals on the course will be exposed to that could trigger asthma: these include vigorous exercise, warm/cold weather, damp weather and allergens. The asthma needs to be well controlled not only for an individual's safety but also so they can participate fully in the course.

Year asthma diagnosed Frequency of exacerbations

Triggers

Number of times emergency room treatment required in last two years
 Date of last attack requiring emergency room treatment
 Dates of asthma attacks requiring hospitalisation

PEAK FLOW READINGS
 Best peak flow Expected peak flow Current peak flow

ASTHMA MEDICATION

| Medication | Dosage | Frequency | Last used |
|------------------------|--------|-----------|-----------|
| Reliever | | | |
| Preventer | | | |
| Other e.g., prednisone | | | |

Doctor – please sign the declaration on page five.

SECTION 6 – MENTAL ILLNESS AND BEHAVIOURAL ADDITIONAL INFORMATION

(To be completed if you answered ‘Yes’ to Medical History Questions 3, 4 or 5)

Outward Bound runs physically and mentally demanding residential courses at our school in Anakiwa. We use the outdoors and the activities as a medium for individuals to challenge themselves and to think about their behaviours and lives. We ask people to go outside their comfort zones, mentally and physically and at times the course can be very demanding. For this reason we ask for more information to support the application of anyone who has a history of depression, attempted suicide or mental illness. This information must be from a specialist or the medical professional who has worked with the individual. Our aim is to ensure that individuals who start the programme are mentally fit and will be capable of attending and completing the programme safely.

What is/was the condition?

What are/were the circumstances and/or what precipitated the condition?

How long did it last? (please include dates)

When were the most recent symptoms of the condition? (please include dates)

How was the condition treated?

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SECTION 6 – MENTAL ILLNESS AND BEHAVIOURAL ADDITIONAL INFORMATION continued...

Medication (please print clearly)

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Dosage

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Date discontinued

| |
|----------------|
| DD / MM / YYYY |
| DD / MM / YYYY |
| DD / MM / YYYY |
| DD / MM / YYYY |
| DD / MM / YYYY |
| DD / MM / YYYY |

What is the current state?

| |
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| |

Has this person ever been suicidal or attempted suicide?

Yes No

Please give details (include dates and current state)

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Has this person displayed aggressive or violent behaviour?

Yes No

Please give details (include dates and current state)

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I certify that:

| |
|------------------|
| PARTICIPANT NAME |
|------------------|

is suitable is not suitable to attend an Outward Bound® course.

Medical Examiner's signature

| |
|-----------|
| SIGN HERE |
|-----------|

Date

| |
|----------------|
| DD / MM / YYYY |
|----------------|

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