

MEDICAL FORM FOR INTERNATIONAL STUDENTS

PLEASE COMPLETE ALL REQUIRED PAGES AND RETURN TO:

Outward Bound Trust of New Zealand • Level 6, 40 Panama Street • PO Box 25 274 • Wellington 6146 • NEW ZEALAND • Fax + 64 (4) 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 New Zealand 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 vary from 8 to 21 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 **+64 (3) 520 8538**.

This Medical must be valid from to

Section 1 must be completed by participant

Sections 2-4 must be completed by Doctor

Section's 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 (please print your answers neatly)

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

MINIMUM FITNESS REQUIREMENT (Please note that if you are unable to meet this minimum requirement you may be asked to leave the course)

Can you comfortably run three kilometres in less than 25 minutes? Yes No

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

Medical and Travel Insurance Policy Numbers

Copies Attached

Yes

- 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 New Zealand 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 New Zealand course is the first concern of the Outward Bound Trust of New Zealand. 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 New Zealand course.
 - The intended recipients of the information are those staff directly involved with my attendance at the Outward Bound School in New Zealand.
 - The information is being collected and held by Outward Bound New Zealand.
 - 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)*

Has the applicant had any of the following;

- | | | | | |
|--|-----|--------------------------|----|--------------------------|
| 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, ADD) (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) 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"/> |
| 20. Current medications taken (please attach): | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

If 'Yes' to any of the above please add details including dates below

If 'Yes' to 1 please complete **Section 5: Asthma Additional Information.**

If 'Yes' to 3, 4 or 5 please complete **Section 6: Additional Information** (Mental Illness and Behavioural)

If 'Yes' to 8 please include details of reaction below.

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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

Examiner's 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 DD / MM / YYYY

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

Outward Bound New Zealand 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 YYYY Frequency of exacerbations

Triggers

Number of times emergency room treatment required in last two years

Date of last attack requiring emergency room treatment DD / MM / YYYY

Dates of asthma attacks requiring hospitalisation DD / MM / YYYY DD / MM / YYYY

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 four.

SECTION 6 – MENTAL ILLNESS AND BEHAVIOURAL ADDITIONAL INFORMATION

(To be completed if you answered yes to Medical History Question's 3, 4 or 5)

Outward Bound New Zealand runs physically and mentally demanding residential courses at our school in Anakiwa, New Zealand. 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?

Medication (please print clearly)

Dosage

Date discontinued

DD	/	MM	/	YYYY
DD	/	MM	/	YYYY
DD	/	MM	/	YYYY

What is the current state?

Has this person ever been suicidal or attempted suicide?

Yes No

Please give details (include dates and current state)

Has this person displayed aggressive or violent behaviour?

Yes No

Please give details (include dates and current state)

I certify that:

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

Medical Examiner's signature

Date

DD	/	MM	/	YYYY
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