

**PLEASE COMPLETE ALL REQUIRED PAGES AND RETURN TO:**

Outward Bound Trust of New Zealand • 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)*

**Outward Bound courses can be both physically and emotionally demanding. Courses vary from 6 – 21 days and activities include running, swimming, rock climbing, kayaking, solo, sailing and tramping in all weather conditions.**

Prospective participants will only be accepted on an Outward Bound course with this Doctor's form recommending acceptance. If the participant is not considered fit, the Doctor should not recommend the participant be accepted. The Doctor is requested to complete this medical form in full. 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 form is valid for 90 days from the date it is 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 0800 654 422.

**ALL INFORMATION PROVIDED IS CONFIDENTIAL**

**SECTION 1** *(completed by you the participant)*

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"/>
Home phone	Work phone	Mobile	Fax
<input type="text" value="( )"/>	<input type="text" value="( )"/>	<input type="text" value="( )"/>	<input type="text" value="( )"/>
Preferred email	Alternative email		
<input type="text"/>	<input type="text"/>		

**MINIMUM FITNESS REQUIREMENT**

*(If you are unable to meet this minimum fitness requirement you may be asked to leave the course at your expense.)*

Can you comfortably run three kilometres in less than 25 minutes? (Does not apply to adapted courses) No  Yes

Can you swim 20 metres with confidence? No  Yes

Do you smoke? (Outward Bound is a smoke free organisation). No  Yes  If 'Yes' how many per day?

**DECLARATION** *(signed by you the participant)*

- 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 Outward Bound. 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 Doctor 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

NAME

DATE

**OFFICE USE ONLY**

COURSE CODE

REGISTRATION NUMBER

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

Has the applicant had any of the following?

- |   |                             |                              |   |
|---|-----------------------------|------------------------------|---|
| 1. Asthma .....   | No <input type="checkbox"/> | Yes <input type="checkbox"/> | <b>If Yes complete Section 5</b>  |
| 2. Epilepsy (Must be seizure free for past ) nYUfg .....  | No <input type="checkbox"/> | Yes <input type="checkbox"/> | <b>If Yes provide letter outlining history</b>  |
| 3. Mental illness. (Depression, Anxiety, Phobia, Eating Disorders, Substance Abuse or other) .....  | No <input type="checkbox"/> | Yes <input type="checkbox"/> | <b>If Yes complete Section 4</b>  |
| 4. Suicidal thoughts /attempts or self harming behaviours .....                                     | No <input type="checkbox"/> | Yes <input type="checkbox"/> | <b>If Yes complete Section 4</b>  |
| 5. Any or a history of any behavioural issues (ADHD/ADD) .....                                      | No <input type="checkbox"/> | Yes <input type="checkbox"/> | <b>If Yes complete Section 4</b>  |
| 6. Any learning difficulties. (Low IQ, dyslexia) .....  | No <input type="checkbox"/> | Yes <input type="checkbox"/> | <div style="border-left: 1px solid black; border-right: 1px solid black; border-bottom: 1px solid black; padding: 10px; margin-left: 20px;">                 If Yes please please write details including dates, severity, sensitivity and last reaction in the box below.             </div> |
| 7. Any recent traumatic experiences or death of relative or friend in past 12 months.....           | No <input type="checkbox"/> | Yes <input type="checkbox"/> |   |
| 8. Any food allergies.....  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |   |
| 9. Any allergy (stings, medicine) .....   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |   |
| 10. Any heart conditions (Please seek approval from specialist if currently under care of one)..... | No <input type="checkbox"/> | Yes <input type="checkbox"/> |   |
| 11. High blood pressure.....  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |   |
| 12. Fainting attacks, blackouts.....  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |   |
| 13. Migraine.....   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |   |
| 14. Diabetes. (HbA1c <8.0 in last 3 months is required).....  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |   |
| 15. Hepatitis, HIV or AIDS related condition .....  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |   |
| 16. Head Injury, concussion, unconsciousness .....  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |   |
| 17. Backache, spinal injury, disc trouble .....   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |   |
| 18. Any knee, ankle or joint injury.....  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |   |
| 19. Any other serious illness, injury, operation or condition .....                                 | No <input type="checkbox"/> | Yes <input type="checkbox"/> |   |
| 20. Currently pregnant. If 'Yes' this excludes a student from attending.....                        | No <input type="checkbox"/> | Yes <input type="checkbox"/> |   |
| 21. Current medications taken .....   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |   |
| 22. Disability (intellectual, physical) .....   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |   |

Medication	Dosage	Frequency

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

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

- |                          |                                 |                                   |
|--------------------------|---------------------------------|-----------------------------------|
| Abdomen .....            | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| Locomotor system .....   | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| Respiratory system ..... | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| Vision .....             | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |

Height <input style="width: 80%;" type="text"/> cm	Weight <input style="width: 80%;" type="text"/> kg	Resting heart rate <input style="width: 80%;" type="text"/>	Blood pressure <input style="width: 80%;" type="text"/> / <input style="width: 80%;" type="text"/>
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Date of last tetanus booster (Please give a booster if required)

Please describe any abnormal findings

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## SECTION 4 – MENTAL ILLNESS AND BEHAVIOURAL ADDITIONAL INFORMATION

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

Outward Bound uses the outdoor activities as a medium for individuals to challenge themselves and to think about their lives. We ask people to go outside their comfort zones, mentally and physically, and at times the course can be very demanding. 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. 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.**

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 commenced

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

Date discontinued

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

What is the current state?


Has this person ever been suicidal, attempted suicide or self harmed?

Yes  No

If 'yes' please give details (include dates and current state)


Has this person displayed aggressive or violent behaviour?

Yes  No

If 'yes' please give details (include dates and current state)


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

It is important to note that there is a wide range of conditions that individuals at Outward Bound will be exposed to that could trigger asthma, these include; vigorous exercise, warm/cold weather, damp weather and allergens. Asthma needs to be well controlled, not only for an individual's safety, but also so they can participate fully in their 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			

**SECTION 6 – DOCTOR'S APPROVAL** (completed by doctor)

Doctor'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 sign one)

**SATISFACTORY – APPLICANT SHOULD BE ACCEPTED**

DOCTOR'S SIGNATURE

DATE

**NOT SATISFACTORY – APPLICANT SHOULD NOT BE ACCEPTED**

DOCTOR'S SIGNATURE

DATE

**DOCTOR'S STAMP**

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