

**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 (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 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 **90 days** 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

**ALL INFORMATION PROVIDED IS CONFIDENTIAL**

**SECTION 1** (completed by you)

First name <input type="text"/>	Middle name <input type="text"/>	Surname <input type="text"/>	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth <input type="text" value="DD / MM / YYYY"/>	Age <input type="text"/>	
Address 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" value="( )"/>	Work phone <input type="text" value="( )"/>	Mobile <input type="text" value="( )"/>	Fax <input type="text" value="( )"/>
Preferred email <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

If 'Yes' how many per day?

**OFFICE USE ONLY**

**COURSE CODE**  **REGISTRATION NUMBER**



### 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 – 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  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

**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 5 – MEDICAL EXAMINER'S APPROVAL *(completed by doctor)*

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

SIGN HERE

DATE  DD /  MM /  YYYY

## 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 uses the outdoors and the 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 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)

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