

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
<input type="text" value="SIGN HERE"/>	<input type="text"/>
	DATE
	<input type="text" value="DD / MM / YYYY"/>

OFFICE USE ONLY

COURSE CODE	<input type="text"/>	REGISTRATION NUMBER	<input type="text"/>
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SECTION 2 – MEDICAL HISTORY (to be completed by Doctor)

Has the applicant had any of the following?

- 1. Asthma No Yes
- 2. Epilepsy (Must be seizure free for past 12 months) No Yes
- 3. Mental illness. (Depression, Anxiety, Phobia, Eating Disorders, Substance Abuse or other) No Yes
- 4. Suicidal thoughts /attempts or self harming behaviours No Yes
- 5. Any or a history of any behavioural issues (ADHD/ADD) No Yes
- 6. Any learning difficulties. (Low IQ, dyslexia) No Yes
- 7. Any recent traumatic experiences or death of relative or friend in past 12 months..... No Yes
- 8. Any food allergies..... No Yes
- 9. Any allergy (stings, medicine) No Yes
- 10. Any heart conditions (Please seek approval from specialist if currently under care of one)..... No Yes
- 11. High blood pressure..... No Yes
- 12. Fainting attacks, blackouts..... No Yes
- 13. Migraine..... No Yes
- 14. Diabetes. (HbA1c <8.0 in last 3 months is required)..... No Yes
- 15. Hepatitis, HIV or AIDS related condition No Yes
- 16. Head Injury, concussion, unconsciousness No Yes
- 17. Backache, spinal injury, disc trouble No Yes
- 18. Any knee, ankle or joint injury No Yes
- 19. Any other serious illness, injury, operation or condition No Yes
- 20. Currently pregnant. If 'Yes' this excludes a student from attending..... No Yes
- 21. Current medications taken No Yes
- 22. Disability (intellectual, physical) No Yes

If Yes complete Section 5
If Yes provide letter outlining history
If Yes complete Section 4
If Yes complete Section 4
If Yes complete Section 4

If Yes please please write details including dates, severity, sensitivity and last reaction in the box below.

Medication	Dosage	Frequency

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

- Cardiovascular system.....Normal Abnormal
- Current mental status.....Normal Abnormal
- Hearing.....Normal Abnormal
- Central nervous system.....Normal Abnormal
- Ears.....Normal Abnormal

- Abdomen.....Normal Abnormal
- Locomotor system.....Normal Abnormal
- Respiratory system.....Normal Abnormal
- Vision.....Normal Abnormal

Height cm Weight kg Resting heart rate Blood pressure

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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