MEDICAL FORM

OFFICE USE ONLY
COURSE CODE

IMPORTANT INFORMATION

Doctor/Nurse Practitioner and participant must read the following before completing the medical form:

About Outward Bound
Courses vary in duration from 5-21 days. Designed to be both physically and mentally challenging, activities can include running, swimming, rock climbing, solo, kayaking, sailing and tramping in all weather conditions.

Medical form validity
This medical form is valid for 90 days* from the date it is completed by a doctor and must be valid until the course start date.

**Mind Body Soul, Classic, and Leaps & Bounds course participants' forms are valid for 180 days, unless told otherwise.*

Acceptance
This medical form must be completed by a medical doctor or nurse practitioner. It will then be reviewed by an Outward Bound Medical Screener/Nurse for final acceptance and confirmation of enrolment. Full disclosure of medical history is necessary to ensure the participant's and others' safety. Medical conditions may not necessarily exclude a participant from attending, unless indicated, as long as the condition can be appropriately managed. Non-disclosure of a medical condition may result in early departure from your course.

Please ensure you complete ALL FIVE PAGES of this medical form.

Both doctor and participant MUST complete the signature section of the final page of this form to be considered.

Please return via email to: enrol@outwardbound.co.nz or **Fax:** +64 4 472 8059

For more information, contact us on 0800 688 927

SECTION 1: PARTICIPANT DETAILS

Completed by PARTICIPANT

FULL NAME

GENDER

DATE OF BIRTH (DD/MM/YY) **AGE**

PHONE

EMAIL

SECTION 2: MEDICAL HISTORY

Completed by DOCTOR OR NURSE PRACTITIONER

HEIGHT (CM) **WEIGHT (KG)**

RESTING HEART RATE **BLOOD PRESSURE**

SMOKING & VAPING

Does the participant smoke? Yes No

If yes, how often?

Does the participant vape? Yes No

If yes, how often?

Outward Bound courses are strictly smoke, vape, drug and alcohol free at all times.

Is the participant able to go smoke & vape-free at Outward Bound?* Yes No

**Nicotine gum/patches are permitted.*

CONTINUED >>

PARTICIPANT NAME

SECTION 2 (CONTINUED)

Completed by DOCTOR OR NURSE PRACTITIONER

Does the participant have, or have they ever had, any of the following:

1. Mental health (anxiety, depression, PTSD, bi-polar, schizophrenia, eating disorder, alcohol/drug treatment or counselling, suicidal thoughts/ attempts, self-harming behaviours) — No ☐ Yes ☐ — If yes, complete section 6

2. Neurodiverse - Autism spectrum disorder (ASD), ADHD, dyslexia etc. — No ☐ Yes ☐ — If yes, complete section 6

3. Asthma/respiratory condition — No ☐ Yes ☐ — If yes, complete section 5

4. Seizures - has participant ever had a seizure?* If yes, please specify type of seizure/diagnosis and date of most recent seizure: — No ☐ Yes ☐

**If yes, a stand-down period applies.*

5. Diabetes - control of HbA1c (53-64 mmol is required) — No ☐ Yes ☐ — Include HbA1c from past 3 months

6. Allergies (food, stings, medicine) — No ☐ Yes ☐ — If yes include severity and last reaction

7. Traumatic experiences or death of family/friend in past year — No ☐ Yes ☐

8. High blood pressure — No ☐ Yes ☐

9. Fainting attacks, blackouts — No ☐ Yes ☐

10. Migraine — No ☐ Yes ☐

11. Hepatitis, HIV or AIDS related condition — No ☐ Yes ☐

12. Learning difficulties — No ☐ Yes ☐

13. Disability (intellectual, physical) — No ☐ Yes ☐

14. Head injury, concussion, unconsciousness — No ☐ Yes ☐

15. Current medication — No ☐ Yes ☐

16. Heart condition — No ☐ Yes ☐

17. Backache, spinal injury, disc trouble — No ☐ Yes ☐

18. Dislocation or joint injury — No ☐ Yes ☐

19. Other serious illness, injury, operation or condition — No ☐ Yes ☐

20. Currently pregnant - if YES participant cannot attend — No ☐ Yes ☐ N/A ☐

If you answered YES to questions 4-20, provide details in the space below. Please also attach any specialist letters.

If extra space is required please attach extra sheet of paper to the back of form

CURRENT MEDICATION	DOSAGE	DATE COMMENCED

PARTICIPANT NAME

SECTION 3: MEDICAL EXAMINATION

Completed by DOCTOR OR NURSE PRACTITIONER

Outward Bound does not require advanced screening tests (e.g. spirometry, audiometry, ECGs) unless clinically indicated

Cardiovascular system	Normal		Abnormal	
Current mental status	Normal		Abnormal	
Central nervous system	Normal		Abnormal	
Hearing	Normal		Abnormal	
Ears	Normal		Abnormal	
Abdomen	Normal		Abnormal	
Locomotor system	Normal		Abnormal	
Respiratory system	Normal		Abnormal	
Vision	Normal		Abnormal	

DESCRIBE ANY ABNORMAL FINDINGS:

SECTION 4: IMMUNISATION

Completed by DOCTOR OR NURSE PRACTITIONER

Has the participant had Measles?

No Yes Unsure

How many doses of the MMR vaccine has the participant had?

0 1 2 Unsure

Vaccination is recommended by public health services due to the 2019 Measles outbreak and the risks associated with bringing people from all over NZ to Outward Bound.

SECTION 5: ASTHMA INFORMATION

Completed by DOCTOR OR NURSE PRACTITIONER if answered YES to question 3

Outward Bound participants will be exposed to a wide range of asthma triggers including vigorous exercise, cold weather, damp weather and allergens. The participant's asthma must be well-controlled, with a current asthma action plan, to ensure their safety and full participation.

YEAR ASTHMA DIAGNOSED

FREQUENCY OF EXACERBATIONS

EMERGENCY TREATMENT REQUIRED IN LAST 2 YEARS?

No Yes If yes, state how many times

DATE OF LAST HOSPITALISATION OR EMERGENCY TREATMENT

TRIGGERS

PEAK FLOW READINGS

Best peak flow	Expected peak flow	Current peak flow

ASTHMA MEDICATION

Medication	Dosage	Date commenced	Date last used

PARTICIPANT NAME

SECTION 6: MENTAL HEALTH INFORMATION

Completed if answered YES to questions 1 or 2

This section must be completed by the health professional who has worked with the participant e.g. counsellor, psychiatrist, doctor.

Outward Bound is mentally demanding - participants will get outside their comfort zone and push their limits. We require full disclosure of any mental health to ensure the participant's and others' safety. Our aim is to ensure participants are mentally fit so they are able to complete their Outward Bound course in full. Note that Outward Bound is unable to provide any counselling, treatment or support for mental health or behavioural issues.

WHAT IS/WAS THE CONDITION/ DIAGNOSIS?

WHAT TRIGGERED THE CONDITION?

WHAT WERE THE SYMPTOMS?

WHEN WERE THE LAST SYMPTOMS (INCLUDING DATES)?

HAS THE PARTICIPANT EVER BEEN SUICIDAL, ATTEMPTED SUICIDE OR SELF-HARMED?

No ☐ Yes ☐ If yes, provide details at the top of the next column

DETAILS OF SELF-HARM OR SUICIDE ATTEMPT

Please include dates and description of events

HAS THE PARTICIPANT DISPLAYED AGGRESSIVE OR VIOLENT BEHAVIOUR?

No ☐ Yes ☐ If yes, provide details, including dates

HOW WAS THE CONDITION TREATED?

Medication	Dosage	Date commenced	Date last used

WHAT IS THE CURRENT STATE?

DETAILS OF THE HEALTH PROFESSIONAL COMPLETING SECTION 6: MENTAL HEALTH

☐ **Tick here if same as the doctor who is completing the rest of this form**

FULL NAME

OCCUPATION

TELEPHONE **EMAIL**

PARTICIPANT NAME

SECTION 7: DOCTOR'S DETAILS

Completed by DOCTOR OR NURSE PRACTITIONER

ARE YOU THE PARTICIPANT'S REGULAR DOCTOR OR NURSE PRACTITIONER? Yes ☐ No ☐

DOCTOR / NURSE PRACTITIONER NAME

MEDICAL CENTRE

TOWN/CITY

EMAIL

TELEPHONE

STAMP

APPROVAL

Completed by DOCTOR OR NURSE PRACTITIONER

As a Registered Medical Practitioner: I have read the important information on the front of this medical form. I confirm that all required sections of this medical form are completed in full. I certify that the health and fitness of the participant is:

Please select one

SATISFACTORY:
PARTICIPANT SHOULD BE ACCEPTED

DOCTOR OR NURSE PRACTITIONER SIGNATURE

TODAY'S DATE

☐☐ / ☐☐ / ☐☐

UNSATISFACTORY:
PARTICIPANT SHOULD NOT BE ACCEPTED

DOCTOR OR NURSE PRACTITIONER SIGNATURE

TODAY'S DATE

☐☐ / ☐☐ / ☐☐

PARTICIPANT DECLARATION

- I declare that the information given in this form is true and complete to the best of my knowledge.
- I understand that if:
  a) I have not disclosed all previous medical conditions or injuries, or
  b) My medical condition changes or I receive an injury after signing this form and do not disclose this to Outward Bound before 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 wellbeing 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/ Nurse Practitioner who signed this form to obtain further information that may be required.
- I acknowledge that, in accordance with the provisions of the Privacy Act 2020, the following information has been brought to my attention:
  a) This form collects personal information about me.
  b) The information is collected to evaluate my suitability to attend an Outward Bound course.
  c) The intended recipients of this information are those staff directly involved with my attendance. Outward Bound staff may share relevant information with other health professionals who may be required to be involved in my health care.
  d) The Health Information Privacy Code 2020 and the Privacy Act 2020, entitles me to have access to, and request a correction of, the information. Where correction is not made, a statement of request for correction will be attached to my records.
  e) The information is being collected and held by Outward Bound.

SIGNATURE

Signed by PARTICIPANT

PARTICIPANT NAME

PARTICIPANT SIGNATURE

TODAY'S DATE

☐☐ / ☐☐ / ☐☐

Please ensure both the Doctor / Nurse Practitioner AND participant signatures have been completed before submitting this form