Instructor Notes	
Office Use Only	Approval

Confidential Medical Record

Complete as directed and return to:

PART I General Information

Employee

Legal Name_____
Gender ☐ Male ☐ Female
Age _____ DOB ____/____/____
Height _____ft. _____ins.
Weight _____lbs.
Occupation _____

Address ___ _____ Apt. # ____
City/State/Zip _____
_____
Daytime Telephone _____
Evening Telephone _____
Cell Phone _____ FAX _____
email _____

Emergency Contact

Name _____
Relationship _____
email _____

Daytime Telephone _____
Evening Telephone _____
Cell Phone _____

Insurance Information *Each employee is responsible for all personal medical expenses and should be covered by his/her own illness and accident insurance. Please attach a photocopy of both the front and back of your insurance card.*

The following information is important for our records: DO YOU HAVE HEALTH INSURANCE? ☐ Yes ☐ No
Insurance Company _____ Policy/Certificate # _____
Prescription Plan # _____ Telephone # (_____)_____

PART II Employee History: Past and Present Medical Information

A. Allergies - Including allergies to medicines, foods, insect bites/stings **NONE ☐ or, list below**

Allergy List Below	Reaction	Medication Required (if any)

B. Medications You Are Currently Taking - If psychiatric medication, please list any taken within the past 2 months
NONE ☐ or, list any you are using including psychiatric, over-the-counter, inhalers, & herbal supplements

Medication List Below	Taken For Symptom/Condition	Dosage	Date Started	Current Side Effects (if any)

C. Immunizations

We recommend that all of our employees have a current tetanus immunization (w/in 10 years), and other immunizations as appropriate to the working environment. Please specify the year of the most recent tetanus booster:

D. Hospitalizations/Emergencies/Urgent Care

NONE ☐ or, please list any hospital, emergency department, or urgent care visits within the past 2 years

Date of Visit/Admittance	Reason	Length of Stay

E. Conditions: History and/or Symptoms - *Please mark an answer for each question*

#	Condition	Y	N	#	Condition	Y	N	#	Condition	Y	N
1	High Blood Pressure	☐	☐	21	Vision Impairment	☐	☐	39	Muscle Cramps	☐	☐
2	Heart Disease	☐	☐	22	Sleep Disorder	☐	☐	40	Intolerance to Warm **or**	☐	☐
3	Irregular Heartbeat	☐	☐	23	Broken Bones w/in 18 Months	☐	☐	41	Cold Temperatures	☐	☐
4	Positive TB test	☐	☐	24	Neck Problem	☐	☐	42	Altitude Problem	☐	☐
5	History of Hepatitis	☐	☐	25	Back Problem	☐	☐	43	Are you currently receiving or have you received within the past year, treatment for mental health issues?	☐	☐
6	Seizure Disorder/Epilepsy	☐	☐	26	Elbow, Wrist, Hand Problem	☐	☐				
7	Bleeding Disorder	☐	☐	27	Shoulder Problem	☐	☐				
8	Blood Disorder/Anemia/Sickle Cell Trait	☐	☐	28	Knee Problem	☐	☐	**Do any of the following mental health issues apply to you?**			
9	Chronic Cough	☐	☐	29	Ankle Problem	☐	☐	44	Depression	☐	☐
10	Asthma	☐	☐	30	Leg or Hip Problem	☐	☐	45	Anxiety	☐	☐
11	Diabetes	☐	☐	31	Foot Problem	☐	☐	46	Eating disorder	☐	☐
12	Hypoglycemia (↓blood sugar)	☐	☐	32	Currently Pregnant	☐	☐	47	Schizophrenia	☐	☐
13	Frostbite	☐	☐	33	Dyslexia	☐	☐	48	Psychotic Disorder	☐	☐
14	Heatstroke	☐	☐	34	ADHD	☐	☐	49	Self-Harming Behavior	☐	☐
15	Circulation Problems	☐	☐	**Do you currently or regularly have any of the following symptoms?**				50	Substance Abuse (Alcohol/Drug)	☐	☐
16	Neurological Impairment	☐	☐					51	Bipolar Disorder	☐	☐
17	Gastrointestinal Problems	☐	☐	35	Chest Pain/Pressure	☐	☐				
18	Genitourinary Problems	☐	☐	36	Shortness of Breath	☐	☐				
19	Endocrine Problems	☐	☐	37	Dizziness	☐	☐				
20	Hearing Impairment	☐	☐	38	Fainting	☐	☐				

If you have answered "yes" to any of the above items (1 – 51), please explain. Include the following bullet points in your explanation:

- Specific symptoms that are occurring
- How long symptom/condition lasts
- Date of last occurrence
- How often symptom/condition occurs
- How you care for symptom/condition
- How symptom/condition restricts your activity in any way, including your ability to run, lift, and climb

Item #	Detailed Description (including restrictions, if any)

F. Blood Pressure - Must be taken within 6 months of course start

Blood Pressure _____/_____ IF BP is over 150/90, please take a second reading:

Date Taken _____ Second Reading _____/_____ Date Taken _____/_____

Blood pressure may be taken with apparatus at local department or drug store.

G. Signature - All information will remain confidential. Failure to disclose information could result in serious harm to you, your students, and your coworkers. By signing this form, you are acknowledging that Outward Bound may request from you access to those medical records that are relevant to your employment with us.

Signature Required

By signing this document I hereby give permission, in the event of an emergency, for any emergency anesthesia, operation, hospitalization or other treatment that may be, in the judgment of a healthcare provider, necessary. I certify that this medical record is complete and accurate to the best of my knowledge and that I have made no attempt to conceal information, and that falsification could be cause for dismissal.

_____ _____

Parent or Guardian or Student over 18 Date