

Outdoor Empowerment

Bridging the Gap Between Inner-city and Outer limits.

Instructor Notes:

Approval:

For office use only

Complete Outdoor Empowerment
And Return PO 35463
to: Syracuse, NY 13235

ID#: _____

Group Name: _____ Date: _____

INSTRUCTIONS: Please answer all of the following questions.

PART I: GENERAL INFORMATION

APPLICANT

NAME _____
GENDER (Circle) M F ID# _____
AG _____ DOB ____/____/____
Do you speak/understand English? (Circle) Y N

ADDRESS _____ APT _____
CITY _____
STATE/ZIP _____
TELEPHONE (Hm) (____) _____ (Wk) (____) _____
(Cell) (____) _____ Email _____

PARENT/GUARDIAN

NAME _____
TELE. (Hm) (____) _____ (Wk) (____) _____
(Cell) (____) _____ Email _____

EMERGENCY CONTACT (If parent/guardian not available)

NAME/RELATIONSHIP _____
TELE. (Hm) (____) _____ (Wk) (____) _____
(Cell) (____) _____ Email _____

ETHNIC BACKGROUND (Optional)

- | | | |
|--|---|---|
| <input type="checkbox"/> Asian | <input type="checkbox"/> Caucasian | <input type="checkbox"/> African American |
| <input type="checkbox"/> Multi-Ethnic | <input type="checkbox"/> Pacific Islander | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> American Indian | <input type="checkbox"/> Other _____ |

INSURANCE INFORMATION

Do you have insurance? (Circle) Y N

Insurance Company _____ Policy # _____ Telephone# _____

PART II MEDICAL INFORMATION

HEIGHT

Feet

Inches

WEIGHT

Lbs.

A. SERIOUS MEDICAL CONDITIONS (Check ALL that apply)

- | | |
|---|--|
| <input type="checkbox"/> Heart Disease or Heart Problems (Other than non-restrictive "normal heart murmur") | <input type="checkbox"/> Head injury in past in which you lost consciousness |
| <input type="checkbox"/> Blood Disorder such as Anemia or Sickle Cell Trait | <input type="checkbox"/> Insulin-Dependent Diabetes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Other (Please Explain) _____ |
| <input type="checkbox"/> Seizure Disorder/Seizure within past year | _____ |

B. CONDITIONS THAT MAY BE AFFECTED BY PROGRAM ACTIVITIES (Check ALL that apply)

- Use of Medical Device (Prosthesis)
 Currently Pregnant
 Food Restrictions Other than Allergies (Please Explain) _____

PLEASE LIST ANY ALLERGIES (FOOD, MEDICATIONS, INSECT Bite/Sting, ENVIRONMENT (Grass,Pollen))

Allergy to: _____ What Happens? _____ Treatment? _____
Allergy to: _____ What Happens? _____ Treatment? _____
Allergy to: _____ What Happens? _____ Treatment? _____

C. COUNSELING (Check ALL that apply)

Are you currently in counseling or have you been within the past year? Y N

Have you experienced or been diagnosed with any of the following

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Suicide | <input type="checkbox"/> Violent Behavior | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Major Depression |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Anxiety | |

D. MEDICATIONS (Please list ALL medications you are currently taking)

Medication _____	For how long? _____	Medication _____	For how long? _____
Medication _____	For how long? _____	Medication _____	For how long? _____

PART III SIGNATURE

Consent is hereby given for the applicant to attend an **OUTDOOR EMPOWERMENT** program and permission is given for any emergency anesthesia, operation, hospitalization or other necessary medical treatment. For the safety of all the participants, all relevant medical information must be disclosed.

Parent's/Guardian's Signature (If applicant is below legal age of consent)

Date

Applicant's Signature

Date