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# Admissions Packet

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“They can do it. We  
can help.”

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Outdoor Achievement Group, L.L.C.

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# Outdoor Achievement Group, L.L.C.

## Youth Behavioral Health Services

### Admissions Packet

“They can do it. We can help.”

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#### Admissions Packet Contents

Welcome to the Outdoor Achievement Group, L.L.C.,

Thank you for considering the Outdoor Achievement Group, L.L.C. The Outdoor Achievement Group, L.L.C., is a Cooperative Wilderness Therapy (CWT) program designed for children and adolescents struggling with a variety of behavioral, emotional, and psychological issues.

Please mail your completed admissions packet to the address below or fax to **(866) 725-7538**.

Outdoor Achievement Group, L.L.C.  
 Attn: Admissions  
 10600 S. Penn  
 Suite 16 #224  
 Oklahoma City, Oklahoma 73170

Lead.

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**Outdoor Achievement Group, L.L.C.**  
Youth Behavioral Health Services  
Admissions Packet

The Sky Is No Limit

**Section I: Child's Personal Information and Emergency Contact Information**

Client's Name (First, Middle Initial, Last): \_\_\_\_\_.

Parent(s) or Guardian(s): \_\_\_\_\_.

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Current Age: \_\_\_\_  Male  Female

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Mobile: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

Shoe Size: \_\_\_\_ Waist Size: \_\_\_\_ in Height: \_\_\_\_ in Weight: \_\_\_\_ lbs

Emergency Contact Name: \_\_\_\_\_.

Emergency Contact Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**\*Please include a color photograph of the child.**

**Section II: General Intake Questions**

Persons living in the same home as the child:

Name	Date of Birth or Age	Relationship to Child

Please list the problems with which you want help for your child:

Primary

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Secondary

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Tertiary

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**Section III: Developmental Factors**

**A. Prenatal History**

- How was the mother's health during pregnancy?  Good  Fair  Poor  Unknown
- Did the mother experience unusual or high levels of stress during the pregnancy?  Yes  No

If yes, please explain

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3. How old was the mother when the child was born? \_\_\_\_\_

4. Number of previous pregnancies? \_\_\_\_\_

5. Number of living children? \_\_\_\_\_

6. Did the mother experience a previous miscarriage or premature baby?  Yes  No

7. Do you recall using any of the following substances or medications during the pregnancy?

(circle appropriate answer)

**Beer or Wine**

- Never
- Once or Twice
- 3-19 Times
- 20-39 Times
- 40+ Times

**Hard Liquor**

- Never
- Once or Twice
- 3-19 Times
- 20-39 Times
- 40+ Times

**Coffee and other Caffeinated Beverages**

- Never
- Once or Twice
- 3-19 Times
- 20-39 Times
- 40+ Times

**Cigarettes**

- Never
- Once or Twice
- 3-19 Times
- 20-39 Times
- 40+ Times

8. Did you take any of the following substances?

- \_\_\_\_\_ Valium (Librium, Xanax)
- \_\_\_\_\_ Tranquilizers
- \_\_\_\_\_ Antisiezure Medications (Dilantin, Phenobarbital)
- \_\_\_\_\_ Antibiotics
- \_\_\_\_\_ Sleeping Pills
- \_\_\_\_\_ Narcotics
- \_\_\_\_\_ Speed or Amphetamines
- \_\_\_\_\_ Other; please specify: \_\_\_\_\_

9. Please indicate which occurred during your pregnancy this child:

	Yes	No
Had Bleeding During the First Three Months		
Had Bleeding During the Second Three Months		
Had Bleeding During the Third Three Months		
Gained 30 or more Pounds		
Gained 15 or less Pounds		
Toxemia		
Rh Incompatibility		
Water Broke 24 Hours Before Delivery		
Eclampsia		
Vomited Often		
Got Hurt or Injured		
Experienced Shock or Unusual Stress		

10. Did you have any infections or illness during your pregnancy with this child?  Yes  No

If yes, please explain.

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**B. Perinatal History**

11. How long was your pregnancy with this child? \_\_\_\_\_

12. How long was your labor? \_\_\_\_\_

13. Were you given any medications to ease the pain during labor?  Yes  No  Don't Know

If yes, please list medications.

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14. Please mark all that apply to the child at the time of birth.

	Yes	No	?
<b>Born With the Cord Around His or Her Neck</b>			
<b>Injured at Birth</b>			
<b>Indications of Fetal Distress</b>			
<b>Had Difficulty Breathing</b>			
<b>Was Jaundiced (yellow skin)</b>			
<b>Was Given Oxygen</b>			
<b>Was One of a Multiple Birth</b>			
<b>Had an Infection</b>			
<b>Was Given Medications</b>			
<b>Had Seizures</b>			
<b>Had Diarrhea</b>			
<b>Gagged Often</b>			
<b>Vomited Often</b>			
<b>Born With Heart or Other Congenital Defect</b>			
<b>Had Difficulty Sucking or Feeding</b>			
<b>Was Very "Jittery"</b>			

Please list and explain other problems experienced during birth.

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15. Please describe the delivery (check all that apply).

- Normal    Cesarean    Induced    Breech    Forceps    Suction

16. What was the child's birth weight? \_\_\_\_\_

17. Did the child experience health complications following birth?  Yes  No

If yes, please explain.

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18. Did the child have any birth Defects?  Yes  No

If yes, please explain.

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19. APGAR Scores (if known): 1 Minute \_\_\_\_\_ 5 Minutes \_\_\_\_\_

20. How long did you stay in the hospital following the child’s birth? \_\_\_\_\_

21. How long did the child stay in the hospital following the birth? \_\_\_\_\_

**C. Postnatal Period and Infancy**

22. Please mark all that apply.

	Yes	No
Did the Infant Experience Feeding Problems		
Was the Infant Colicky		
Did the Infant Experience Sleep Pattern Difficulties		
Did You Experience Problems With the Infant’s Alertness		
Meningitis		
Rotovirus		
Slow Weight Gain		
Anemia		
Lead or Other Poisoning		
Did the Infant Get Sick Following Immunization		

Please list and explain other problems experienced during infancy.

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23. Did the child experience any health problems during infancy?  Yes  No

If yes, please explain.

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24. Was the child an “easy” baby? Did the baby cry a lot? Did the baby follow a schedule fairly well?

Very Easy  Easy  Average  Difficult  Very Difficult

25. Please mark the appropriate column for each behavioral dimension as an infant and toddler.

	Very	Somewhat	Neutral	Somewhat	Very	
Passive						Demanding
Carefree						Anxious
Indifferent						Inquisitive
Inactive						Active
Social						Withdrawn
Moody						Even Temper
Vocal						Quiet
Bashful						Bold

**D. Developmental Milestones**

26. Please use a checkmark to indicate the age at which the child first reached the following developmental milestones.

At what age did the child?	3-6 Months	7-12 Months	Over 12 Months	Don't Know
Sit Up				
Crawl				
Walk				
Speak Single Words (other than "mama or dada")				
String Two or More Words Together				
Toilet Trained (bladder control)				

27. Does the child currently have bladder control problems?  Yes  No

If yes, please indicate frequency and time of day.

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If yes, has the child ever been continent?  Yes  No

28. At what age was the child toilet trained (bowel control)?

Under 1 Year  1-2 Years  2-3 Years  3-4 Years  Don't know

29. Does the child currently have bowel control problems?  Yes  No

If yes, please indicate frequency and time of day.

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30. Approximately how long did toilet training take?

Less Than 1 Month  1-2 Months  2-3 Months  More Than 3 Months

31. In comparison to other children of his or her age, how well did the child perform the following tasks?

	Much Worse	Worse	About the Same	Better	Much Better	Not Applicable
Cutting With Scissors						
Pasting						
Dressing Self						
Coloring Within the Lines						
Working Puzzles						
Drawing Freehand						
Learning Colors						
Learning Shapes						
Learning Numbers						
Learning Alphabet						
Throwing a Ball						
Kicking a Ball						
Skipping						
Tying Shoelaces						
Running & Changing Directions						

**Section IV: Medical History**

1. Please use a checkmark to indicate the child’s performance in the following areas.

	Very Good	Good	Fair	Poor	Very Poor
Hearing					
Vision					
Gross Motor Coordination					
Fine Motor Coordination					
Speech Articulation					

2. Has the child experienced any chronic health problems (e.g. asthma, allergies, diabetes)?  Yes  No

If yes, please describe and indicate age of onset.

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3. Which of the following illnesses has the child had?

(circle all that apply)

- Mumps
- Measles
- Scarlet Fever
- Encephalitis
- Seizures
- Allergies
- Frequent Colds

- Chicken Pox
- Whooping Cough
- Pneumonia
- Ear Infections
- Lead Poisoning
- Frequent Runny Nose
- Frequent Sinus Infections

Has the child had other illnesses or diseases not listed above? If yes, please explain.

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4. Did the child experience ear problems before the age of 1?  Yes  No

5. Approximately how many ear problems has your child experienced in his or her life?

0-2  3-5  6-10  10+

6. Does the child tend to have 4 or more ear problems each year?  Yes  No

7. Has the child had an ear problem within the past 6 months?  Yes  No

8. Has the child ever had an ear problem that lasted 3 months or longer?  Yes  No

9. Has the child ever been seen by an ear doctor?  Yes  No

If yes, please provide the doctor's name, contact information, and date of last visit.

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10. Has the child ever had tubes placed in her or her ears?  Yes  No

If yes, please indicate the child's age at the time of surgery.

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11. Has the child's hearing ever been screened or checked?  Yes  No

If yes, please describe the findings and indicate the child's age at the time of screening.

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12. Has the child's vision ever been screened or checked?  Yes  No

If yes, please describe the findings and indicate the child's age at the time of screening.

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13. Has the child had any accidents resulting in the following?

	Yes	No
<b>Broken Bones</b>		
<b>Head Injury</b>		
<b>Stomach Pumped</b>		
<b>Lost Teeth</b>		
<b>Sever Lacerations Requiring Stitches</b>		
<b>Severe Bruising</b>		
<b>Eye Injury</b>		

14. Has the child suffered any serious accidents or injuries not indicated above?  Yes  No

If yes, please describe.

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15. Approximately how many serious accidents or injuries has the child suffered?

- None  1-3  4-7  8-12  Over 12

16. Has the child ever had surgery for any of the following conditions?

	Yes	No
<b>Tonsillitis</b>		
<b>Hernia</b>		
<b>Eye, Ear, Nose &amp; Throat</b>		
<b>Urinary Tract Infection</b>		
<b>Burns</b>		
<b>Adenoids</b>		
<b>Appendicitis</b>		
<b>Digestive Disorder</b>		
<b>Leg or Arm</b>		
<b>Other:</b>		

17. What was the duration of the child's hospitalization for the conditions described above?

- 1 Day  2-3 Days  4-6 Days  1-4 Weeks  1-2 Months  Over 2 Months

18. Do you suspect the child is currently or has ever used alcohol or drugs?  Yes  No

If yes, please describe suspicions.

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19. Does the child have any problems sleeping?  Yes  No

If yes, please describe.

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20. Is the child a restless sleeper; are his or her bed covers often in disarray in the morning?  Yes  No

21. Does the child snore?  Yes  No  Don't Know

22. Does the child have any appetite control problems?  No  Overeats  Under eats

23. Please provide the name and contact information for the child's primary care physician.

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24. Is the child currently receiving treatment for any non mental health related conditions?  Yes  No

If yes, please describe.

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25. Is the child currently taking any medications?  Yes  No

If yes, please list current medications.

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**Section V: Treatment History**

1. Has the child ever been prescribed any of the following medications?

	Yes	No	If Yes, Duration of Use
Ritalin			
Concerta			
Cylert			
Adderall			
Focalin			
Tranquilizers			
Anticonvulsants			
Antihistamines			
Metadate			
Strattera			
Other:			

2. Has the child ever participated in any of the following forma of psychological treatment?

	Yes	No	If Yes, Duration of Treatment
Individual Psychotherapy			
Group Psychotherapy			
Family Therapy with Child			
Inpatient Evaluation			
Residential Treatment			

**Section VI: School History**

Current School: \_\_\_\_\_ Grade: \_\_\_\_\_

1. Please summarize the child’s school progress. Include details such as grades, any formal testing that was completed, how the child interacted with peers and teachers, and any pertinent behavioral issues.

Kindergarten

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Grades 1-3

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Grades 4-6

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Grades 7-8

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Grades 9-12

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26. Has the child ever had any type of special education program?  Yes  No

If yes, please describe the program and indicate duration.

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2. Has the child ever been:

	Yes	No	If Yes, How Many Times?
<b>Suspended From School</b>			
<b>Expelled From School</b>			
<b>Received Lunch Detention or After School Detention</b>			
<b>Retained in Grade</b>			

3. Have any additional instructional modifications been attempted?  Yes  No

If yes, please describe the modification and indicate results.

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4. Please use a checkmark to indicate the child's performed in the following subjects?

	Below Average	Average	Above Average
Reading			
Spelling			
Math			
Penmanship			
Social Studies			
Science			

**Section VII: Current Behavioral Concerns**

1. What strategies have been tried to address specific behavioral problems?

- Verbal Reprimand
- Time Out (isolation)
- Removal of Privileges
- Rewards
- Physical Punishment
- Acquiescence of Child
- Avoidance of Child

2. On average, what percentage of time does your child comply with initial commands?

- 0-20%    20-40%    40-60%    60-80%    80-100%

3. On average, what percentage of time does your child eventually comply with commands?

- 0-20%    20-40%    40-60%    60-80%    80-100%

4. To what extent are you and your spouse consistent with respect to disciplinary strategies?

- Most of the Time    Some of the Time    None of the Time

**Section VIII: Family and Social History**

1. Where was the child born (City, State)? \_\_\_\_\_

2. Who was the child raised by? \_\_\_\_\_

3. Are the child's parents divorced?  Yes  No

If yes, please answer questions 4-8

4. How old was the child at the time of the divorce? \_\_\_\_\_

5. Who has legal custody of the child? \_\_\_\_\_

6. Has either parent remarried?  Yes  No

If yes, please explain.

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7. Who does the child currently live with? \_\_\_\_\_

8. What are the visitation agreements?

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9. Does the child have siblings living at home?  Yes  No

If yes, list the name and age of siblings living at home, and describe relationship.

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10. Does the child have siblings not living at home?  Yes  No

If yes, list the name and age of siblings not living at home, and describe relationship.

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11. Describe the child's relationship with parent(s) or guardian(s):

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12. Does the child have close friends?  Yes  No

If yes, list the first name and age of close friends, and describe relationship.

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13. Describe the child’s relationship with peers.

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14. Describe the child’s relationship with teachers other adults.

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15. Is the child sexually active?

Yes  No  Don’t Know

If yes, has the child ever been tested for Sexually Transmitted Disease (STD)?

Yes  No  Don’t Know

16. Please indicate whether the child has experienced the following events.

	Yes	No	If Yes, How Old Was The Child
Family Moved to a New Home			
Child Changed Schools			
Child Separated From Family for 2-Weeks or More			
Brother or Sister Leaving Home			
Divorce of Parents			
Increase in Arguments Between Parents			
Decrease in Arguments Between Parents			
Marital Separation of Parents			
Being Raised by a Single Parent			
Multiple Caregivers			
Parent Has a Live-In Boyfriend or Girlfriend			
Marriage of Parent to Stepparent			
Addition of Step Brothers or Sisters to the Household			
Birth of a Sibling or Mother Becomes Pregnant			
Non-Family Member Living With the Family			
Addition of a Third Adult to the Family			
Mother Begins Work			
Change in Father’s Occupation Requiring Increase Absence From Home			
Improvement in Parent’s Financial Status			
Worsening of Parent’s Financial Status			
Loss of Job by Parent			
Child is a Victim of Violence			
Family Member a Victim of Violence			
Child Acquired a Visible Deformity			
Brother or Sister Experiences Serious Trouble			
Parent Arrested or in Serious Trouble With the Law			
Serious Illness or Accident Requiring Hospitalization of Child			
Serious Illness or Accident Requiring Hospitalization of Brother or Sister			
Serious Illness or Accident Requiring Hospitalization of Parent			
Death of a Brother or Sister			

Death of a Parent			
Death of a Grandparent			
Death of a Friend			
Parent Began Counseling			
Parent's Mood or Feelings About Life Became Worse or Much Worse			
Parent's Mood or Feelings About Life Became Better or Much Better			
Discovery by Child of Being Adopted			
Suspicion of Sexual Abuse			
Suspicion of Physical Abuse			
	Yes	No	If Yes, How Old Was The Child

17. Which of the following symptoms of **INNATTENTION** have persisted for at least six months to a degree that is maladaptive and inconsistent with the child's developmental level? Please read each statement carefully and select those that apply to your child.

- Often fails to give close attention to details or makes careless mistakes in schoolwork or other activities.
- Often has difficulty sustaining attention in tasks or play activities.
- Often does not seem to listen when spoken to directly.
- Often does not follow through on instructions and fails to finish schoolwork or chores (not due to oppositional behavior or failure to understand instructions).
- Often has difficulty organizing tasks and activities.
- Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework).
- Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, or books).
- Often and easily distracted by extraneous stimuli.
- Is often forgetful in daily activities.

18. Which of the following symptoms of **HYPERACTIVITY-IMPULSIVITY** have persisted for at least six months to a degree that is maladaptive and inconsistent with the child's developmental level? Please read each statement carefully and select those that apply to your child.

- Often fidgets with hands or feet or squirms in seat.
- Often leaves seat in classroom or in other situations in which remaining seated is expected.
- Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents may be limited to subjective feelings of restlessness).
- Often has difficulty playing or engaging in leisure activities quietly.
- Is often "on the go" or often acts as if "driven by a motor".

- Often talks excessively.
- Often blurts out answers before questions have been completed.
- Often has difficulty awaiting turn.
- Often interrupts or intrudes on others (e.g., butts into conversations or games).

19. Please read each statement carefully and select those that apply to your child.

- Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age seven.
- Some impairment from the symptoms is present in two or more settings (e.g., at school and at home).
- Symptoms create significant impairment in social and or academic functioning.

20. Which of the following are considered to be significant problems at the present time?

	Yes	No	If Yes, Age of Onset
Often Loses Temper			
Often Argues With Adults			
Often Defiant or Refuses to Comply With Adults' Requests			
Often Deliberately Annoys People			
Often Blames Other for His or Her Mistakes			
Is Easily Annoyed by Others			
Often Angry or Resentful			
Often Spiteful or Vindictive			

21. Which of the following are considered to be significant problems at the present time?

	Yes	No	If Yes, Age of Onset
<b>Often Bullies, Threatens, or Intimidates Others</b>			
<b>Often Initiates Physical Fights</b>			
<b>Has Used a Weapon Capable of Causing Serious Harm to Others</b>			
<b>Has Been Physically Cruel to People</b>			
<b>Has Been Physically Cruel to Animals</b>			
<b>Has Stolen While Confronting the Victim (face to face with the victim)</b>			
<b>Has Forced Someone Into Sexual Activity</b>			
<b>Has Deliberately Set a Fire With the Intention of Causing Serious Damage</b>			
<b>Has Deliberately Destroyed Others' Property</b>			
<b>Has Broken Into Someone Else's House, Car, or Building</b>			
<b>Often Lies to Obtain Goods, Favors, or to Avoid Obligations</b>			
<b>Has Stolen Items of Value Without Confronting Victim</b>			
<b>Often Stays Out at Night Against Parent Desires</b>			
<b>Has Run Away From Home Overnight</b>			
<b>Often Truant From School</b>			

22. Which of the following are considered to be significant problems at the present time?

- Excessive distress when separation from home or attachment figures occurs or is anticipated?
- Excessive worry about losing, or possible harm befalling, major attachment figures?
- Excessive worry that an event such as getting lost or being kidnapped will result in separation from a major attachment figure?

23. Please use a checkmark to indicate behaviors which apply to the child’s biological father and his family.

	Father	Father’s Mother	Father’s Father	Father’s Brother	Father’s Sister
Problems With Aggressiveness, Defiance, and Oppositional Behaviors					
Problems With Attention, Activity, and Impulse Control as a Child					
Learning Disabilities					
Did Not Graduate From High School					
Mental Retardation					
Psychosis or Schizophrenia					
Bipolar Disorder or Manic Depression					
Depression					
Anxiety Disorder That Impaired Adjustment					
Tics or Tourette’s					
Alcohol or Substance Abuse					
Problems With the Law					
Physical Abuse as a Child					
Sexual Abuse as a Child					

24. Please use a checkmark to indicate behaviors which apply to the child’s biological mother and her family.

	Mother	Mother’s Mother	Mother’s Father	Mother’s Brother	Mother’s Sister
Problems With Aggressiveness, Defiance, and Oppositional Behaviors					
Problems With Attention, Activity, and Impulse Control as a Child					
Learning Disabilities					
Did Not Graduate From High School					
Mental Retardation					
Psychosis or Schizophrenia					
Bipolar Disorder or Manic Depression					
Depression					
Anxiety Disorder That Impaired Adjustment					
Tics or Tourette’s					
Alcohol or Substance Abuse					
Problems With the Law					
Physical Abuse as a Child					
Sexual Abuse as a Child					

25. Please use a checkmark to indicate behaviors which apply to the child’s biological siblings.

	Brother	Brother	Sister	Sister
Problems With Aggressiveness, Defiance, and Oppositional Behaviors				
Problems With Attention, Activity, and Impulse Control as a Child				
Learning Disabilities				
Did Not Graduate From High School				
Mental Retardation				
Psychosis or Schizophrenia				
Bipolar Disorder or Manic Depression				
Depression				
Anxiety Disorder That Impaired Adjustment				
Tics or Tourette’s				
Alcohol or Substance Abuse				
Problems With the Law				
Physical Abuse as a Child				
Sexual Abuse as a Child				

**Section IX: Narrative**

1. In the space provided below please write a few paragraphs outlining your child’s current behavioral, emotional, and or psychological challenges. When possible, please provide specific examples. If necessary please attach additional sheets or use the back of this page.

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## Outdoor Achievement Group, L.L.C.

Youth Behavioral Health Services

Child's Self Assessment

### The Sky Is No Limit

**Child's Self Assessment (for children and adolescents aged 12-17)**

Hello, my name is \_\_\_\_\_ . I am \_\_\_\_\_ years old.

These are some of my favorite activities:

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For the most part I would describe myself as a \_\_\_\_\_ person.

These are some of the things I would like to change about my life:

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This is how I would describe my relationship with close friends:

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This is how kids at school would describe me:

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This is how I would describe myself:

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## Outdoor Achievement Group, L.L.C. History and Medical Questionnaire

### The Sky Is No Limit

Participant's Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent(s) or Guardian(s) Name \_\_\_\_\_

#### Medical History

	YES	NO
Have you had any serious injury or illness since your last check-up?		
Do you have an ongoing or chronic illness?		
Have you ever been hospitalized overnight?		
Have you ever had surgery?		
<b>Are you currently taking any medication? (List Medications Below)</b>		
Do you think you are in good health?		
Do you have any allergies (include food allergies)?		
Have you ever experienced rash or hives following exercise?		
Have you ever passed out during or after exercise?		
Have you ever been dizzy during or after exercise?		
Have you ever had chest pain during or after exercise?		
Do you tend to tire more quickly than your friends during exercise?		
Have you ever had racing of your heart or skipped heartbeats?		
Have you had high blood pressure or high cholesterol?		
Have you ever been told you have a heart murmur?		
Has a family member or relative dies of heart problems or sudden death before age 50?		
Is there a family history of heart problems in a close relative younger than age 50?		
Have you had severe heart infection?		
Has a physician ever denied or restricted your participation in sports for any heart problem?		
Have you had a severe viral infection within the last 6-months?		
Do you have any current skin problems (itching, rash, blisters, acne, warts, or fungus)?		
Have you ever had a head injury or concussion?		
Have you ever been knocked out, become unconscious, or lost your memory?		
Have you ever had a seizure?		
Do you have frequent or severe headaches?		
Have you ever had numbness or tingling in your arms, hands, legs, or feet?		
Have you ever become ill following exercise in the heat?		
Do you cough, wheeze, or have difficulty breathing during or after exercise?		
Do you have asthma?		
Do you have seasonal allergies which require medical treatment?		
Have you had any problem with your eyes or vision?		
Do you wear glasses, contacts, or protective eyewear?		
Have you broken or fractured any bones or dislocated any joints?		
Have you had problems with pain or swelling in muscles, tendons, bones, or joints?		
Do you want to weigh more or less than you do now?		
Do you feel stressed out?		

**Explain "Yes" answers here (use reverse side if needed) :**

**Physical Exam** (this section must be completed by a medical care provider)

Participant's Name: \_\_\_\_\_ . DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_/\_\_\_\_

Vision: R 20/\_\_\_\_\_ L 20/\_\_\_\_\_ Corrected: YES NO

MEDICAL	NORMAL	ABNORMAL (findings)	INITIALS*
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL	NORMAL	ABNORMAL (findings)	INITIALS*
Head			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

\*This is a station-based exam only.

Cleared     Not Cleared     Cleared with Restrictions (see below)

Restrictions/Reasons:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that I have on this date examined this individual and that, on the basis of the examination and the student's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this individual to participate in supervised outdoor activities including hiking, canoeing, and rock climbing (**Note restrictions above**).

\_\_\_\_\_ \_\_\_\_\_  
Examiner's Signature

\_\_\_\_\_ \_\_\_\_\_  
**Examiner's Name and Address (print or stamp)**    **Telephone**

## Outdoor Achievement Group, L.L.C. Authorization for Release of Information

### I. Client's Personal Information

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### II. Authorization for Release of Information

I, \_\_\_\_\_, \_\_\_\_\_, hereby authorize  
*(Parent or Legal Guardian Name)* *(Social Security Number)*

the disclosure and sharing of medical, mental health, and educational information as outlined in Section III related to my minor child (Section I) between the Outdoor Achievement Group, L.L.C., 10600 South Penn, Oklahoma City, Oklahoma 73170, and \_\_\_\_\_

*(Name and Address of Treatment Facility, Institution, or Individual)*

### III. Information to be Disclosed, Method of Disclosure, and Purpose of Disclosure

Please include the following information related to the medical and or mental health treatment of my minor child (Section I).

**Information to be Disclosed**

- Records Pertaining to Wilderness-Based Therapy
- Complete Medical Record
- Complete Mental Health Record
- Academic Records
- Disciplinary Records

**Method of Disclosure**

- Copies Via Mail (including electronic mail) or Fax
- Verbally

**Purpose of Disclosure**

- To Permit Coordination and Collaboration of Care

\*The following items should be excluded from disclosure:

\_\_\_\_\_  
\_\_\_\_\_

### IV. Parent or Legal Guardian Authorization

At any time, I may revoke this consent orally or in writing. I understand that the revocation will not be effective retroactively for information exchanges that have already occurred. Unless otherwise noted, this consent expires one (1) year from the date of my signature below.

\_\_\_\_\_  
*(Signature of Parent or Legal Guardian)* Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
*(Signature of Witness)* Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_