To be filled out by the Participant

Open Roads

Participant Medical Record

Complete as directed and return to:

Open Roads Academy, Inc.
1223 Wilshire Blvd. #351
Santa Monica, California 90403

To be completed by the applicant:

PART I General Information

Course Starting Date _____/_____/_____

Applicant Name_____

Address _____ **Apt. #** _____

Gender (circle one) **Male** **Female**

City/State/Zip _____

Age at Course Start _____ **DOB** _____/_____/_____

___ _____

Height _____**ft.** _____**in.**

Daytime Phone # (_____)_____

Weight _____**lbs.**

Evening Phone # (_____)_____

FAX # (_____)_____

Social Security # _____

email Address _____

Father/Guardian

Name _____

Address _____

City/State/Zip _____

Occupation _____

Home Telephone # (_____)_____

Work Telephone # (_____)_____

FAX # / email _____

Mother/Guardian

Name_____

Address _____

City/State/Zip _____

Occupation _____

Home Telephone # (_____)_____

Work Telephone # (_____)_____

FAX # / email _____

Emergency Contact (not parent/guardian)

Name _____ **Relationship** _____

Daytime Phone # (_____)_____

Evening Phone # (_____)_____

Cell Phone # (_____)_____

Family Physician

Name _____

Telephone # (_____)_____

Fax # (_____)_____

Do you speak and understand English? (circle one) Yes No

Insurance Information

Each participant is responsible for any medical expenses and should be covered by his/her own illness and accident insurance. Please attach a photocopy of both front and back of your insurance card.

The following questions must be answered for our insurance records:

Insurance Company _____**Policy / Certificate #**_____

Prescription Plan # _____**Telephone #** (_____)_____

Signature Required

Consent is hereby given for the applicant to attend a The Call Academy program and permission is given for any emergency anesthesia, operation, hospitalization or other treatment which may become necessary.

All information will remain confidential. You should know that over the years, many students with a variety of medical/ psychological difficulties have successfully completed our programs, but we must be aware of these conditions. Failure to disclose such information could result in serious harm to you and your fellow students.

If you arrive at the program start with a pre-existing condition or injury which has not been indicated on your medical form and you are subsequently forced to leave the program because of that condition, you will be charged an evacuation fee and will not receive a refund of tuition.

_____ _____

Parent / Guardian Signature (if applicant is under legal age) **Date**

_____ _____

Applicant Signature **Date**

PART II Participant History: Past and Present Medical Problems

Conditions and Symptoms (Please mark yes or no to each item):

#	Condition	Y	N	#	Condition	Y	N	#	Condition	Y	N
1	High Blood Pressure			23	Skin Problem			45	Shoulder Problem		
2	Heart Disease			24	Frostbite			46	Knee Problem		
3	Heart Murmur			25	Circulation Problems			47	Ankle Problem		
4	Irregular Heartbeat			26	Bedwetting			48	Leg Problem		
5	Family History of Heart Attack			27	Headaches			49	Foot Problem		
6	Tuberculosis			28	Head injury w/ neurological impairment			50	Currently Pregnant		
7	Recent Exposure to TB			29	Stomach Ulcers			51	Medical Equipment/ Devices		
8	Positive TB Test			30	Intestinal Problems			52	Learning Disability		
9	Active Hepatitis			31	Heatstroke			53	Special Diet		
10	History of Hepatitis			32	Bladder Infection			54	Unexpected Weight Loss		
11	Seizure Disorder/ Epilepsy			33	Difficulty Urinating			55	Chest Pain/ Pressure		
12	Seizure w/in Past Year			34	Kidney Problems			56	Heart Palpitations		
13	Bleeding Disorder			35	Thyroid Problems			57	Frequent Shortness of Breath		

14	Blood Disorder/ anemia/ sickle cell trait			36	Endocrine Problems			58	Unexplained Sweating		
15	Chronic Cough			37	Hearing Impairment			59	Frequent Dizziness		
16	Recurrent lung infections			38	Vision Impairment			60	Frequent Fainting		
17	Asthma			39	Motion Sickness			61	Heartburn		
18	Diabetes			40	Sleep Walking			62	Muscle Cramps		
19	Hypoglycemia			41	Broken Bones			63	Intolerance to Warm/Cold Temperatures		
20	Anorexia Nervosa			42	Neck Problem			64	PMS/ Menstrual Problems		
21	Bulimia			43	Back Problem			65	Other:		
22	Cancer			44	Arm Problem						

If you have answered "yes" to any of the items on the previous page, please explain below. Include the following:

- **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)

Allergies (please circle one): none see below
(Include any allergies to medicines, foods, insect bites)

Allergy (list below)	Reaction	Medication Required (if any)

Part III Personal History

Counseling History

#	Counseling History (based upon past two years)					Yes	No
1	Have you been in counseling with a psychiatrist, psychologist, guidance counselor, or other counselor within the past two years?						
2	Are you currently in counseling or treatment with a counselor, psychiatrist, psychologist, or prescribing physician?						
3	Please arrange for a release of information with your counselor and/or prescribing physician so we may contact them for further information as part of this screening process. Have you done so?						
4	Please circle the appropriate responses that indicate the reason for counseling:						
	Academic/career	Divorce	Family issues	Maintenance of medication			
	Substance Abuse	Depression	Eating disorder	Suicide	Other:		
5	Name of current (or most recent) counselor: _____						
6	Counselor phone #: ( ) fax #: ( ) email address:						
7	Name of prescribing physician: _____						
8	Physician phone #: ( ) fax #: ( ) email address:						

Lifestyle

#	Issue	Yes	No	Further Information	
1	Do you use alcohol			How Much?	How Often?
2	Do you use tobacco?			How Much?	How often?

3	Do you use drugs (other than alcohol or prescription) on a regular basis?			Which One(s)?	How Often?
4	Do you have a history or a current problem with substance abuse or dependency?			Substance abused?	Last used?
5	Have you been on probation or had any involvement with the justice system?			Date?	Reason?