A Place Beyond

Self-Reported Health Screen

Name: Date:

Site: Session Dates:

Height: Weight:

Age:

Full Disclosure: In the interest of the health and well-being of both yourself and other participants please answer the questions honestly and completely on this health form. Answering "YES" to any of the questions below will not automatically disqualify you from participating in a session. If we have questions on your capacity to successfully complete some or all activities, we will contact you to discuss it. Failure to disclose a health condition that becomes relevant during the session may result in dismissal from A Place Beyond ("APB").

I realize that failure to disclose information could result in serious harm to myself, fellow participants, and staff. I agree to inform APB should there be any change in my health status prior to the start of the course. On the basis of the session description, and what I know or suspect about my physical and psychological health, I am fully capable of participating in this APB session.

By my signature, I confirm that the information provided on this form will be an accurate and complete representation of my health history.

****Participant's Signature**_____ Date:_____**

You are not fully accepted until this health form has been reviewed and approved by APB.

ABP disinfects all wilderness water with chlorine dioxide or by boiling. Chlorine dioxide may not be effective against cryptosporidium. Immunocompromised people may with to obtain an appropriate water filter.

Please check the box marked YES or NO for each item. **If you check YES, please explain briefly in the space provided or attach an additional page.** You must answer each question.

General Medical History

Do you currently have a history of:	YES	NO
1. Breathing problems (including Asthma)?	☐	☐
Do you have an inhaler or inhalers? Name(s) of inhalers		
What factors might trigger an attack?		
Have you ever been hospitalized)?	☐	☐
When was your last episode?		

Do you currently have a history of:	YES	NO
2. Gastrointestinal disturbances?	☐	☐
Description:		
3. Diabetes?	☐	☐
4. Bleeding or blood disorders?	☐	☐
Description:		
5. Hepatitis or other liver disease?	☐	☐
6. Neurological problems? Epilepsy? Seizures?	☐	☐
Description:		
7. Dizziness/vertigo or fainting episodes?	☐	☐
8. Migraines? How Frequent and are they debilitating?	☐	☐
Description:		
9. Disorders of the urinary or reproductive tract?	☐	☐
Description:		
10. Do you have any history of cardiac illness or significant risk factors, such as known Coronary artery disease, hypertension, diabetes mellitus, hyperlipidemia, tachyarrhythmia, symptomatic bradycardia (syncope, dizziness), unexplained chest pain (especially with exercise), or immediate family history of early cardiac death (<50 years old)?	☐	☐
Depending on your history, risk factors and age, a stress ECG or waiver from your cardiologist may be required.		
11. In the past three years, have you had any knee, hip, ankle, leg or foot injuries (including sprains) and/or surgery?	☐	☐
If YES:		
a. Do you have full range of motion?	☐	☐
b. Do you have full strength?	☐	☐
c. Are they recurrent? How many times have they occurred?		
d. What is the most rigorous activity participated in since the injury/surgery?		
12. In the past three years, have you had any arm, elbow or back injuries (including sprains) and/or surgery?	☐	☐
If YES:		
a. Do you have full range of motion?	☐	☐
b. Do you have full strength?	☐	☐
c. Are they recurrent? How many times have they occurred?		
d. What is the most rigorous activity participated in since the injury/surgery?		

Do you currently have a history of: YES NO

13. Have you sustained a head Injury? Loss of consciousness? For how long? ☐ ☐
    If YES, please describe the frequency and severity:

Mental Health

Applicants with a history of a mental health disorder within the past three years, which may have required psychotherapy, medication, hospitalization or residential treatment, need to be in a sustained period of stability before they will be accepted for a session. Applicants should have a history of being gainfully occupied such as attending school or employed. APB is not appropriate for applicants just leaving residential treatment facilities.

14. Have you ever been diagnosed with a mental health condition? ☐ ☐
15. Are you currently prescribed medication or engaged in psychotherapy for any of the conditions or symptoms noted below? ☐ ☐

    Please indicate any of the following conditions or symptoms that have been present

    ☐ Suicide (thoughts, ideation, attempt) ☐ ADHD ☐ Autism spectrum disorder
    ☐ Substance use disorder (drugs/ alcohol) ☐ Anxiety ☐ PTSD
    ☐ Eating disorder (anorexia/bulimia) ☐ Depression ☐ Self-harm
    ☐ Obsessive-compulsive disorder ☐ Bipolar disorder
    ☐ Academic/career/family issues ☐ Other:

    Please provide specific details and dates of diagnoses and psychotherapy

16. Do you have any physical, cognitive, or sensory condition that would require consideration? ☐ ☐
    Description:

17. Do you plan to take any prescription or non-prescription medications during the session? ☐ ☐

Some parts of an APB session, e.g. a backpacking trip, take place in remote areas where access to medical care may be one or more days away. Participants must understand the use of any prescription medications they may be taking. All participants who are required by their personal

physician, psychiatrist or health care provider to take prescription medications on a regular basis must be able to do so on their own without supervision or assistance from APB staff.

Please list any medications you plan to take:

Medication	Dosage	Date	First Prescribed?	For What Condition?
_____	_____		_____	_____
_____	_____		_____	_____

Allergies

Regardless of the allergen, individuals with a history of severe allergic (anaphylactic) reactions are required to bring a personal supply of epinephrine, preferably in a pre-loaded auto-injector, and know how to use it.

Do you currently have a history of:	YES	NO
18. Allergies to or a medically related intolerance to any food?	☐	☐
19. Dietary preferences? (e.g., vegetarian, vegan, gluten free)	☐	☐
20. Description: (APB may not be able to accommodate all preferences)		
21. Allergic reactions to insect bites, bee or wasp stings, or medications resulting in hives, swelling of face/lips or difficulty breathing?	☐	☐

Cold, Heat, Altitude, and Other

22. Frostbite or Raynaud's Syndrome?	☐	☐
23. Heat stroke or other heat related illness?	☐	☐
24. Acute mountain sickness, high altitude pulmonary/cerebral edema?	☐	☐
25. Do you have any disease or history of surgery not already mentioned? Description:	☐	☐
26. Do you exercise regularly?	☐	☐

Activity	Frequency	Duration/Distance
_____		
_____		

27. Swimming ability (choose one): Non-Swimmer Recreational Competitive
28. Do you have experience swimming in outdoor/wild bodies of water ☐ ☐
29. Do you smoke, vape or use tobacco products? ☐ ☐
    Tobacco (or nicotine) and vaping is not allowed on ABP courses or property. Initial_____
30. Do you drink alcohol? Approximately how may drinks per week? ☐ ☐
    Description:
    Responsible use of alcohol will be allowed for participants above the legal limit in accordance with APB's policies available on our participant portal. Initial_____
31. Do you use marijuana? ☐ ☐
    Marijuana is not allowed during ABP courses or property even in states which have legal recreational laws. Initial _____

APB SUGGESTS A TETANUS IMMUNIZATION WITHIN 10 YEARS OF THE START DATE OF THE COURSE

If medications or health condition changes prior to course start, please inform APB

Participants are required to have their own health insurance. Please complete this form so that we have information concerning your insurance coverage. It is your responsibility to make sure your insurance will cover you for the duration of the course.

Student's Name

Birth Date (dd/mm/yyyy)

Please Attach a Photocopy of Your Insurance Card.

NAME AND ADDRESS OF PERSON UNDER WHOSE NAME THE POLICY IS CARRIED

Name Street Address

City, State/Province Zip/Postal Phone Date of Birth

INSURANCE COMPANY INFORMATION

Name Policy Number

Group Number (if you have one) Agreement Number (if you have one)

ADDRESS WHERE CLAIMS MUST BE SUBMITTED

Name Street Address

City, State/Province Zip/Postal Phone

IF GROUP INSURANCE, GIVE NAME OF GROUP (EMPLOYER, UNION OR ASSOCIATION THROUGH WHICH THE STUDENT IS INSURED)

Name

PLEASE PROVIDE EMERGENCY CONTACTS

Emergency Contact #1

Name Relationship

Address Phone

Email

Emergency Contact #2

Name Relationship

Address Phone

Email