

Beyond Boundaries

Medical Form

Everyone participating in the Beyond Boundaries trip must fill out Part 1 of the Medical Form.

The only instance where Part 2 must be filled out is if the participant has received a spinal cord injury less than one year ago. If that is the case, Part 2 of the Medical Form must be filled out by the **participant's physician**.

Original signatures are required, so please mail or drop off the completed form to:

Spinal Cord Injury Association of Illinois
Steve Brockway
1032 South LaGrange Road
LaGrange, IL 60525

If you have any questions, please call 708-352-6223.

Participant Medical Form: *Beyond Boundaries*

Part I (To be completed by the participant)

Date: ___/___/___

Name (Last) _____ (First) _____ (MI) _____

Team Affiliation (Rehab Facility): _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Birth ___/___/___ Health Insurance: _____ Policy #: _____

Emergency contact: _____ Relationship: _____ Phone: _____

Diagnosis (if applicable): _____

Spinal Cord Injury (if applicable)

Date of Injury ___/___/___

Level: _____ Complete ___ Incomplete ___

Cause: _____

Other medical conditions (if applicable): _____

List all past surgeries (procedure and date): _____

Medications you are currently taking (prescription and over-the-counter): _____

Allergies (list and describe): _____

Dietary Restrictions _____

Medical History

(circle one)

Seizures: No Yes (explain) _____

Diabetes No Yes (explain) _____

Insulin dependent No Yes (explain) _____

Hypertension No Yes (explain) _____

High blood pressure medications No Yes (explain) _____

Heart disease No Yes (explain) _____

Lung disease No Yes (explain) _____

Asthma No Yes (explain) _____

Heat related problems No Yes (explain) _____

Other No Yes (explain) _____

Do you now participate in outpatient therapy? No Yes (explain) _____

For the purposes of participation in the *Beyond Boundaries* program, permission is given to Beyond Boundaries staff and its representatives to seek medical care in case of an emergency for the above person.

Signature of participant or Parent / Guardian if under 18: _____ Date: ___/___/___

Part II (To be completed by physician if participant received SCI less than one year ago)

Date: ___/___/___

Participant's Name: _____

Diagnosis (list all): _____

Impairments (list all): _____

Height: _____ Weight: _____ Pulse: _____ BP: _____ Sex: _____

Physical exam	Normal	Abnormal	Explanation of abnormalities
Head / neck	_____	_____	_____
Eyes / visions	_____	_____	_____
Ears / hearing	_____	_____	_____
Heart / lungs	_____	_____	_____
G.U.	_____	_____	_____

Orthopedic Exam:

ROM Loss / contractures: _____

Joint Laxity / instability: _____

Other: _____

Dates of hospitalization over last two years with admitting diagnoses:

Significant "Abnormal Test" (EKG/X-ray/lab):

Approval for participation in *Beyond Boundaries*, a four day outdoor adventure program involving a variety of physical activities under the supervision of trained personnel: _____ Yes _____ No

Comments / restrictions: _____

Physician Information

Physician Name (please print): _____

Physician Signature: _____ Date: ___/___/___

Street address: _____ City: _____ State: ___ Zip: _____

Phone: _____

Do not fax or email this form. Original signatures are required.