Instructor Notes

Office Use Only

Follow-up

Participant / Physician Medical Record

To be completed by the applicant & guardian

Program Name **HAWK program**
Program Starting Date Aug 14th 2010

Please fill out this form, scan, attach to an email and send back to randy@mtnspirit.org

Complete as directed and return to: Mountain Spirit Institute POB 626Sunapee, NH 03782 Tel: 603.381.8364 Fax: 630.604.9313 Email: randy@mountainspirit.org

PART I General Information

1	**Name:**	**2**	**Gender: Male ☐ Female ☐**
3	**Age at Program Start:**	**4**	**Birth date:**
5	**Height: __________ ft. __________ in.**	**6**	**Weight: __________lbs.**
7	**Occupation:**	**8**	**Social Security #:**
9	**Address:** **Apt. #**	**10**	**City/State/Zip:**
11	**Daytime Phone #:**	**12**	**Evening Phone #:**
13	**FAX #:**	**14**	**E-mail Address:**
15	**Father/Gardian:**	**16**	**Mother/Guardian:**
	Address:		**Address:**
	City/State/Zip:		**City/State/Zip:**
	Occupation:		**Occupation:**
	Home Telephone:		**Home Telephone:**
	Work Telephone:		**Work Telephone:**
	FAX # / E-mail:		**FAX# / E-mail:**
17	**Emergency Contact (other than parent/guardian):**	**18**	**Family Physician:**
	Relationship:		**Telephone #:**
	Daytime Phone #:		**FAX #:**
	Evening Phone #:	**19**	**Do you speak and understand English?**
	Cell Phone #:		**Yes ☐ No ☐**
20	**Insurance Information:** *Each participant is responsible for any medical expenses and should be covered by his/her own sickness and accident insurance. The following questions must be answered for our insurance records.*		
	Insurance Company Name:		**Policy/Certificate #:**
	Prescription Plan #: **Note:** *Please attach a photocopy of both front and back of your insurance card*		**Telephone #: (_____)__________________**

Signature Required

Consent is hereby given for the applicant to attend an Mountain Spirit Institute 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 is not 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

To be completed by the applicant. *Please FILL in EVERY blank!*

A. Conditions and Symptoms

#	Condition	Y	N	#	Condition	Y	N	#	Condition	Y	N
1	High Blood Pressure			24	Frostbite			47	Ankle Problem		
2	Heart Disease			25	Circulation Problems			48	Leg Problem		
3	Heart Murmur			26	Bedwetting			49	Foot Problem		
4	Irregular Heartbeat			27	Headaches			50	Currently Pregnant		
5	Family history of heart attack			28	Head injury with neurological impairment			51	Medical Equipment / Devices		
6	Tuberculosis			29	Stomach Ulcers			52	Learning Disability		
7	Recent Exposure to TB			30	Intestinal Problems			53	Special Diet		
8	Positive TB test			31	Heatstroke			54	Unexpected Wght Loss		
9	Active Hepatitis			32	Bladder Infection			55	Other		
10	History of Hepatitis			33	Difficulty Urinating			***Do you currently or regularly have any of the following symptoms?***			
11	Seizure Disorder			34	Kidney Problems						
12	Seizure w/in past year			35	Thyroid Problems			56	Chest Pain / Pressure		
13	Bleeding Disorder			36	Endocrine Problems			57	Heart Palpitations		
14	Blood disorder/anemia/ sickle cell trait			37	Hearing Impairment			58	Frequent Shortness of Breath		
15	Chronic Cough			38	Vision Impairment			59	Unexplained Sweating		
16	Recurrent Lung Infections			39	Motion Sickness			60	Frequent Dizziness		
17	Asthma			40	Sleep Walking			61	Frequent Fainting		
18	Diabetes			41	Broken Bones			62	Heartburn		
19	Hypoglycemia			42	Neck Problem			63	Muscle Cramps		
20	Anorexia Nervosa			43	Back Problem			64	Intolerance to warm or		
21	Bulimia			44	Arm Problem			65	Cold Temperatures		
22	Cancer			45	Shoulder Problem			66	PMS / Menstrual Problems		
23	Skin Problem			46	Knee Problem			67	Other		

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

- What specific symptoms 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)*

B. *Allergies*
(Including allergies to medicines, foods, insect bites/stings)

NONE ☐ ***or…***

Allergy List Below	Reaction	Medication Required (if any)

C. *Medications you are currently taking*
(If psychotropic medication(s), please list any taken within the past 2 months)

NONE ☐ **or… please list any medications you are using, including psychiatric and over-the-counter**

Medication List Below	Taken For Symptom/Condition	Dosage Size/ Frequency	Date Started	Current Side Effects (if any)

NOTE: If you are currently taking a medication, bring double amounts in separate, non-breakable, waterproof containers along with dosage instructions

D. *Required Immunization – Tetanus*

Must be within ten (10) years of your Program starting date. _______________

E. Hospitalizations / Emergencies / Urgent Care

NONE ☐ **or…** please list any hospital, emergency department, or urgent care visits within the past 2 years

Date of Visit / Admittance	Reason	Length of Stay

F. Personal History

#	*Personal 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 2 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 briefly describe your loss and how you feel you've been coping with this loss:		
5	Name of current (or most recent) counselor: ______ Phone # (_____)______ FAX # (_____)______ E-Mail Address ______		
6	Name of prescribing physician: ______ Phone # (_____)______ FAX # (_____)______ E-Mail Address ______		

G. Life-Style

#	*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 currently have a substance abuse problem (alcohol, drugs, etc.)?			If yes, please describe:
4	Do you have a history of substance dependency?			Substance(s): Last Used:

H. Current Exercise Activity (Needed as important assessment tool)

Please list the activities you engage in daily or weekly which indicate your current fitness level… Be sure to include activities such as walking a pet, mowing your lawn--or after school activities like playing basketball or skate boarding.

Activity	*Frequency*	*Approximate Time / Distance*	*Leisurely*	*Moderately*	*Intensely*

I. Pertinent Participant Comments:

____

____

____

J. Required Immunization – Tetanus

Must be within ten (10) years of your Program starting date:______________

Additional Comments:

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