Aspen Network – MEDICAL HEALTH HISTORY FORM

Must be completed/signed by participant's medical doctor/practitioner – and emailed to Aspen Network ASAP, please.

Your patient is applying to participate in an Aspen Network program (www.aspennetwork.net) and we want all participants to be as healthy and happy as possible. To this end, please provide the following information:

_____	_____	_____	_____
Patient's First Name	**Middle Initial**	**Last Name**	**DOB**

1. Does patient have any known medication allergies? If so, please list:

2. Patient's medications and dosages?

3. Any medication changes in last 24 months? Reasons?

4. Any acute psychiatric symptoms and interventions?

5. Any hospitalizations within last 24 months? Reasons?

6. What do you see as the patient's primary strengths?

7. Has the patient ever been aggressive, self-injurious, threatening or had suicidal ideation?

8. Are there any camp activities from which the patient should be exempted for health reasons? Please explain:

9. Special considerations: Are there any physical, mental, psychological or behavioral conditions requiring medication, treatment or special restrictions while at Aspen Network CAMP or PODs. Please describe, including any special accommodations necessary. Note that Aspen Network will need to be supplied with any necessary medications and medical equipment (e.g., Epi-pens and prescription medications labeled by prescribing physician).

10. In my opinion the above-named patient is physically able to participate in a summer camp with activities including: swimming, a 5-7 mile moderate hike with backpacking and boating. (Elevation should be considered, as some activities will be at elevations around 7,000 feet.)

Medical Professional:

Name _____ **Signature** _____ **Date** _____

Important: *Please complete, date and email this electronic form ASAP to info@aspennetwork.net.*

In addition*, please print out and physically sign the form and snail-mail it to Aspen Network, 15 Vallecito Lane, Orinda, CA 94563*