Camper's Name: ____
DOB: ________________

Please return to campweekaneatit@gmail.com by May 1, 2019. If you have questions, please contact Jill Waddell at 770-312-9722.

THIS FORM MUST BE SUBMITTED AS PART OF THE APPLICATION IF:
(1) Applicant has been diagnosed with a behavioral or mental health condition (e.g., ADD/ADHD, Anxiety, Depression, PTSD, OCD);
(2) Applicant has seen a mental health professional (e.g., social worker, psychologist, psychiatrist) in the past 12 months, **AND/OR**;
(3) Applicant has been prescribed or is currently taking a psychoactive medication for any reason.
THIS FORM MUST BE COMPLETED BY: **(1)** Applicant's mental health professional (social worker, psychologist, psychiatrist, etc.), if applicable, **OR**; **(2)** The medical professional that prescribed the medication or diagnosed the behavioral, emotional, or mental health condition.

Name of Person Completing Form: ____
Profession: __________________Relationship to Applicant: _________________________

What initially prompted treatment?
__family-initiated __PMD mandate __school referral __other:_____________________
When did treatment begin? __________________________
How is patient currently seen?: ____regularly ____as needed
Date of Most Recent Visit: ________Number of Visits in Past 12 Months: _________
Most recent/current disposition of treatment & involvement with patient:

Behavioral, Emotional or Mental Health Diagnosis/Reason for Treatment:

Date of Diagnosis (if formal DSM diagnosis): ______________________________________
Essential Meds for Diagnosis: ____
Criteria met that led to diagnosis: ____
Behavioral manifestations that may appear at camp & suggested ways to manage:

To your knowledge, is there or has there ever been concern about any of the following?
(Check all that apply.):
___Passive or active suicidal ideation or plans ____Impulse control ____Aggression
If any of these items are checked, please explain:

Can this child function at camp with only **basic** camp care--group supervision?
____**YES** ____**NO**
please explain and detail if there are limitations/concerns with your suggestion:

CONTINUE TO NEXT PAGE

Page 2 Mental Health form:

Camper Name: ____

I understand that the above listed individual is seeking to participate in a special overnight camp for kids with Celiac disease and gluten intolerance, which will provide basic care during camp in a group setting with high activity.

Based on this understanding and my work with this individual, I believe Camp Weekaneatit should:
____**ACCEPT** or _____ **DECLINE** this applicant

Comments/limitations/restrictions:

Please assist with providing best practices to support us with this camper in adjusting to group living at our camp program and any stressors/triggers and suggestions on best way to assist them.

Provider Name: ____________________________________
Phone Number(s): ____________________________________
Signature: ____

Date: ____________________________________