2020 Mental Health Form

Please return to campweekaneatit@gmail.com by YOUR ASSIGNED DEADLINE. If you have questions, please contact Jill Waddell at 770-312-9722.

Camper's Name: ____

DOB: _________________

If your child does NOT need this form, please write N/A in blank:________________

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. (4) Applicant takes ADD/ADHD medication

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:

CONTINUE

Camper Name: ____

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:

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 in a structured schedule.

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

Comments/limitations/restrictions:

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