



# **Santiam Crossing**

WILDERNESS • EDUCATION • SERVICE • TREATMENT

## **Application Packet Part II**

Participant's Name \_\_\_\_\_ Date \_\_\_\_\_



## PARTICIPANT APPLICATION - Part II

Santiam Crossing School  
PO Box 482 • Scio, OR 97374  
(503) 394-4294 • (503) 394-7096/fax

### 1. Youth's Developmental History

Prenatal and birth events (please note any parental alcohol and drug use during pregnancy):

Physical Development History:

Early Childhood Milestones:

Early Social Development:

Early Intellectual / Educational History:

Is your child adopted? If yes, age adopted:

Victim of Abuse / Neglect:

Any serious accidents, or other shocks or traumas?

Sexual development / problems:

**Participant's Name** \_\_\_\_\_ **Date** \_\_\_\_\_

2. What was the student like (health, temperament, behavior, activities, attitudes, family relationships, friends):

Between ages 7-10:

Between ages 11-13

3. Please list and briefly describe any emotional/mental problems this child has had in the past; and if he/she got help with them, the names of his/her counselors or treatment programs, and approximate dates:
4. List any siblings, maternal and paternal parents, grandparents, aunts, or uncles who have had mental health problems (attention-deficit / hyperactivity disorder, depression, bipolar, schizophrenia, suicide or serious attempts), and indicate what problems and approximately when.
5. Describe any alcohol or drug use or abuse you believe your child has engaged in, or may have engaged in. Explain how it has affected their relationships with family members and friends.
6. Has your child been drug tested? If yes, when did the testing take place and what were the results?

Participant's Name \_\_\_\_\_ Date \_\_\_\_\_

7. Have you ever found drug/alcohol paraphernalia in your child's room or in his/her possession? If yes, please describe.

8. Please answer the following questions about your child's substance use:

- |  |  |                             |                |                              |                             |
|--|--|-----------------------------|----------------|------------------------------|-----------------------------|
| Uses by self?                            | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No | Black out?     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Uses only with others?                   | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No | Vomiting?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Injection drugs?                         | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No | Hangovers?     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Using Daily                              | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No | Ever pass out? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does the child think s/he has a problem? | <input type="checkbox"/> Yes <input type="checkbox"/> No |                             |                |                              |                             |

Estimate child's substance abuse/addiction:

Drugs	Age of First Use	Start (Year/Age) of Regular Use	Current Amount & Frequency	Greatest Amount & Frequency
Tobacco				
Caffeine				
Alcohol				
Marijuana				
Methamphetamine				
Cocaine				
Hallucinogens: LSD/Mushrooms/ Other				
Inhalants				
Opiates: Heroin/Opium/ Valium/Other				
Miscellaneous: Ecstasy/Other				

Please indicate the drug of choice ( \* )

9. List any siblings, maternal and paternal parents, grandparents, aunts, or uncles who have had problems with alcohol or drug use, and indicate what the problem was and approximately when.



Participant's Name \_\_\_\_\_ Date \_\_\_\_\_

## Mental Health Treatment History

Please fill in information below for student.

PROVIDER #1: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Interventions (individual/group/family therapy, medication, outpatient, residential, hospital, etc.):

Diagnosis:

Response (including treatment compliance and/or resistance):

PROVIDER #2: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Interventions (individual/group/family therapy, medication, outpatient, residential, hospital, etc.):

Diagnosis:

Response (including treatment compliance and/or resistance):

PROVIDER #3: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Interventions (individual/group/family therapy, medication, outpatient, residential, hospital, etc.):

Diagnosis:

Response (including treatment compliance and/or resistance):



### MEDICAL HISTORY

To be filled out by applicant's parents/guardians

Student's Physician: \_\_\_\_\_ Physician's Phone: (\_\_\_\_) \_\_\_\_\_

The existence of any type of heart irregularity in your child may put them at high risk. It is important that you are completely forthcoming with any and all information you have regarding the following questions:

- Yes No Has your child ever passed out during or after exercise?
- Yes No Has your child ever been dizzy during or after exercise?
- Yes No Has your child ever had chest pain during or after exercise?
- Yes No Has your child had high blood pressure or high cholesterol?
- Yes No Has your child ever been told he/she has a heart murmur?
- Yes No Has any family member or relative died of heart problems or of sudden death before age 50?
- Yes No Has your child had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?
- Yes No Within the last year?
- Yes No Has your child ever participated in sports? If so, what sports and when.
- Yes No Has your child ever discontinued their participation due to chest discomfort or shortness of breath?
- Yes No Has any physician ever denied or restricted your child's participation in sports for any heart problems?

If "yes" to any of the above questions, please explain:

### Medication Alert

Our staff carries the following medications that may be given to a child in the field. Please check "yes" to indicate that we can administer the specific medication to your child or "no" if you don't want a specific medication given to your child.

#### Prescription Medications

- Yes No Albuterol Inhaler (Proventil)
- Yes No Doxycycline
- Yes No Alprazolam (Xanax)
- Yes No Amoxicillin (Trimox)
- Yes No Cephalexin (Keflex)
- Yes No Ciprofloxacin (Cipro)
- Yes No Prednisone (Deltasone)
- Yes No Epinephrine
- Yes No Epi-Pen
- Yes No Hydrocodone/APAP (Vicodin)
- Yes No Silver Sulfadiaz Cream (Silvadene)
- Yes No Sulfamethoxazole-Trimethoprim (Septra, SMZ-TMP)

#### Non-Prescription Meds

- Yes No Antacid
- Yes No Anti-diarrheal
- Yes No Benadryl
- Yes No Decongestant
- Yes No Ibuprofen
- Yes No Ipecac Syrup
- Yes No Laxative
- Yes No Tylenol
- Yes No Anti-Fungal Cream
- Yes No Miconazole Nitrate Cream ("Monistat 3")

Participant's Name \_\_\_\_\_ Date \_\_\_\_\_

**A copy of student's full immunization record MUST BE SUPPLIED**

Date of current tetanus shot? (Normally good for ten years) \_\_\_\_\_ (Must be current)

Any intravenous drug use in the last six months? Yes No

If student is female, is it possible that she is pregnant? Yes No

Does the student have any health conditions, currently use (or has used in the past) any prescription medications? Yes No If yes, please describe:

Please use the following checklist, and describe (below and on back, if necessary) any medical events, and all medical events and treatment from the last two years.

- |                     |                              |                             |                    |                              |                             |
|---------------------|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|
| Pregnancy           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Broken Bones       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Venereal Disease    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dislocations       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Eating Disorders    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Injured Muscles,   |                              |                             |
| Substance Abuse     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Joints, Ligaments  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Depression          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver/Kidney       |                              |                             |
| Schizophrenia       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Problems           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other Mental        |                              |                             | Lack of Bowel or   |                              |                             |
| Health Issues       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bladder Control or | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                     |                              |                             | Recent Bedwetting  |                              |                             |
| Current Tetanus     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tuberculosis        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Trouble      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Infectious Diseases | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Skin Infections     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Operations          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Descriptions of problems and how handled (please describe all yes-marked items):

Asthma Yes No

If yes, any hospital / emergency room visits or nocturnal episodes? Yes No Please explain:

Allergies Yes No

If your child/student has any allergies, describe EXACTLY what causes them, what the reactions are, the seriousness, and what countermeasures / medications, if any, are necessary.

**Participant's Name** \_\_\_\_\_ **Date** \_\_\_\_\_

Is your child experiencing any pain?      Yes      No

If yes, please answer the following questions:

What initiated the pain? Sudden or gradual?

What makes the pain better or worse?

Describe the pain.

Where is the pain located?

Please rate the pain on a scale from 1-10 (1 = no pain and 10 = severe pain)

How long has your child been in pain?

Has your child had any injuries or medical conditions in the past year?   Yes   No   If yes, describe.

Does your child have any history of severe dehydration/heat exposure/heat exhaustion?   Yes   No   If yes, explain.

Does your child currently have any injuries or illnesses, such as sprains, colds, bronchitis, or bladder infections? If so, is he/she taking medications for them, and what are they? (Also, please describe type of medication, dosage, and frequency of administration.)

Is your child a competent swimmer?   Yes   No   If no, what is his/her comfort level around water?

Participant's Name \_\_\_\_\_ Date \_\_\_\_\_

Please list all medications that your child is currently taking:

Medication Name	How Long Has Child Taken Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I have included a copy of my child's complete immunization record. **(Must be included)**

**Our wilderness therapy curriculum involves strenuous physical activity. I recognize that failure to fully disclose information may put my child at greater risk. The above information is true and complete to the best of my knowledge.** Feel free to call us to consult about any health concerns you may have for your child/student.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**PARENT AUTHORIZATION AND CONSENT FOR HEALTH CARE**

Santiam Crossing shall have the right to give first aid to the student and to engage the service of a physician or dentist, or to hospitalize a student if it deems necessary. The cost of such service, including expenses for both the student and the staff member who accompanies him/her during the period of illness and in rejoining the group, medicines and ambulance service, but excluding first aid service, shall be charged to the parent/guardian and paid by the parent/guardian.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Participant's Name \_\_\_\_\_ Date \_\_\_\_\_



**Nutritional Screen**

Student's Age: \_\_\_\_\_

Is your child:  Vegetarian  Vegan

Brief description of student's current diet:

Food Allergies:  Yes  No If Yes, describe:

Foods student does not eat:

Does student eat:  Breakfast  Lunch  Dinner  Snacks

Does student eat with his/her family?  Yes  No

Does student have a medical condition that would warrant a special medical diet?  Yes  No If yes, explain:

Does student have any eating disorders?  Yes  No If yes, describe:

Student's daily caffeine consumption (coffee, tea, chocolate):

\_\_\_\_\_  
Signature of Person Completing Screen Form

\_\_\_\_\_  
Date

Participant's Name \_\_\_\_\_ Date \_\_\_\_\_



## Client Prescription Medication Inventory

Santiam Crossing staff hold and dispense any prescription or non-prescription medication that your child may need. It is critical that Santiam Crossing staff have accurate information about each medication that your child takes as well as adequate medication supplies.

Most medications that a client might be taking can be used during their stay at Santiam Crossing. It is important that the physician completing the physical be aware of all of the medications that your child will be taking during any portion of their treatment at Santiam Crossing. For this reason, we require that this form be completed by parents or guardians aware of current medication needs and reviewed by the physician completing the physical. All physicians providing care need to be aware of all prescription medications your child is on.

Please ensure that sufficient amounts of medications accompany your child to Santiam Crossing.

Client Name \_\_\_\_\_ Date \_\_\_\_\_

### Medications to be taken during admission to Santiam Crossing

Medication	Date first taken	Reason for taking	Dosage and schedule	Quantity per day	Total needed for two months

**Parents** - please make sure the quantities in the last column accompany your child upon admission.

---