HMI

Additional Medical History & Information Forms

Attached are a series of additional forms that you may or may not need:

	Form Name	Who Should Complete This Form:
☐	ALLERGY and/or DIETARY RESTRICTIONS Form	Any student with any known allergies of any type must complete this form. Additionally, this form must be completed by any students with dietary restrictions (medical, religious, or ethical).
☐	ADD/ADHD or Learning Disorder Form	Any student with a past or current history of Attention Deficit Disorder and/or Attention Deficit and Hyperactivity Disorder or a learning disorder must complete this form.
☐	MEDICATIONS Form	Any student who will be taking any medications while attending an HMI program must complete this form for each medication. This includes prescriptions, over-the-counter medications, daily supplements, herbal remedies, and any other medications the student will be bringing to HMI. Photocopy this form as needed for additional medications.
☐	MENTAL HEALTH Form	Any student with a past or current history of mental health issues must complete this form.
☐	ORTHOPEDIC Form	Any student with a non-resolved and/or ongoing orthopedic type injury of any type should complete this form. Additionally, any student with a history of serious orthopedic injury should complete this form.

*In addition, please note that all students **must have a physical completed within 12 months of the start date of their HMI program**. You may use the form provided by HMI or the one provided by your health care provider.*

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High Mountain Institute
ALLERGY and/or DIETARY RESTRICTIONS Form

If applicable, to be completed by parent/s and attached to the General Medical History & Information Forms

Student Name **HMI Program** **Today's Date**

ALLERGY and/or *DIETARY RESTRICTIONS* Related Medical History & Information Form

On the medical form, you listed that the HMI student has allergies (i.e. bee/insect stings, shellfish, iodine, nuts, dairy, other foods, pollen, medications, and any other known allergies) and/or dietary restrictions. When we have the proper information we can accommodate many allergies. Please complete the questionnaire below and return it to HMI. Responding as soon as possible and as thoroughly as possible will help us!

Allergy/Allergen: **Alternative/related/other names:**

When diagnosed with this allergy:

How diagnosed to this allergen:

Symptoms during an allergic reaction (what happens?):

During a reaction: face swelling and/or difficulty breathing (anaphylactic reaction)? ☐ YES ☐ NO

Does the student take any medication for this allergy? (if yes be sure to complete the medications information form)? ☐ YES ☐ NO

Has the student ever been hospitalized for this particular allergy? ☐ YES ☐ NO (If YES, explain in detail on separate sheets as necessary)

Is the student on an allergy desentization program? ☐ YES ☐ NO (If YES, will this require treatments while at HMI and please explain in detail)

Does the student have and carry epinephrine for this allergy? ☐ YES ☐ NO (If YES, the student must bring **two** delivery devices to HMI)

Additional Information:

Allergy/Allergen: **Alternative/related/other names:**

When diagnosed with this allergy:

How diagnosed to this allergen:

Symptoms during an allergic reaction (what happens?):

During a reaction: face swelling and/or difficulty breathing (anaphylactic reaction)? ☐ YES ☐ NO

Does the student take any medication for this allergy? (if yes be sure to complete the medications information form)? ☐ YES ☐ NO

Has the student ever been hospitalized for this particular allergy? ☐ YES ☐ NO (If YES, explain in detail on separate sheets as necessary)

Is the student on an allergy desentization program? ☐ YES ☐ NO (If YES, will this require treatments while at HMI and please explain in detail)

Does the student have and carry epinephrine for this allergy? ☐ YES ☐ NO (If YES, the student must bring **two** delivery devices to HMI)

Additional Information:

Please attach additional sheets as necessary

DIETARY RESTRICTIONS

To assist us in planning expedition rations and on-campus meals, please describe any medical, religious, or ethical dietary restrictions or special needs. **If the dietary restriction involves a food allergy, please be sure to answer the questions above**.

Please attach additional sheets as necessary

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If applicable, to be completed by parent/sand attached to the General Medical History & Information Form

Student Name **HMI Program** **Today's Date**

ADD/ADHD or Learning Disorders Related Medical History & Information Form

On the medical form, you listed that the HMI student has been diagnosed with ADD/ADHD. We ask a series of questions of any student who has this condition because we can accommodate most cases of ADD/ADHD when we have the proper information. Please complete the questionnaire below and return it to HMI as soon as possible. Responding as soon as possible and as thoroughly as possible will help us!

Does the student have: ☐ Attention Deficit Disorder (ADD) ☐ Attention Deficit Hyperactivity Disorder (ADHD) ☐ Both ADD & ADHD

When was the ADD and/or ADHD diagnosed:

What behaviors led to the diagnosis:

During the last two years, has the student taken any medications for ADD/ADHD? ☐ YES ☐ NO

Is he/she currently taking any medications for ADD/ADHD? ☐ YES ☐ NO (If YES, please complete the Medications Form)

What happens if the student misses a dose?

Under the current treatment, how does the student's ADD/ADHD manifest itself?

Does the ADD/ADHD interfere with school or work? If so, how?

What, if any, are the prescribed accommodations for academic type school work? Homework? Testing? Please attach additional sheets as necessary.

For HMI summer programs (HMI Summer Term, High Peaks Adventure), does the student normally take the medication or plan to take the medication during the summer at HMI?

Treating Counselor/Therapist/ Physician's Name: Treating Counselor/Therapist/ Physician's Phone:

Additional Information:

Please attach additional sheets as necessary

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If applicable, to be completed by parent/s and attached to the General Medical History & Information Forms

Student Name **HMI Program** **Today's Date**

MEDICATIONS Related Medical History & Information Form

As a way to better serve the needs of all HMI students, we ask, that in consultation with your family physician, you please complete the following questionnaire regarding the student's medications (taken for current, chronic or episodic condition/s) and return it to us. This questionnaire will be kept on file with the student's other medical information and be used as a resource for the HMI faculty and staff. If the student is taking more than one medication, please complete a separate form for each medication (copy this form as necessary). Please complete the following information (a complete sheet) for **EACH** medication the student will be bringing to HMI including prescriptions, over-the-counter medications, dietary supplements, herbal remedies, etc.

Medication Brand Name: **Medication Generic/Chemical Name:**

Reason for taking this medication:

Start Date using this medication: End Date (if known):

Regular Dose:

Frequency & Time of Dose(s):

Triggers (signs & symptoms) for dosing, if applicable (e.g. onset of shortness of breath):

This medication should be taken: ☐ with food ☐ with water ☐ on an empty stomach ☐ other:

Common Side Effects:

Uncommon Side Effects:

Harmful interactions (i.e. don't give with ibuprofen):

Indications or contraindications for use regarding: intensive sun exposure, altitude (5-14,000 ft.), rigorous exercise, cold exposure, heat exposure?

Missed dose procedure: ☐ Skip dose ☐ Take immediately ☐ Double dose at next scheduled time ☐ Call physician ☐ Other:

What happens if the student misses a dose?

Prescribing Physician's Name: Prescribing Physician's Phone:

Will the student come to HMI with sufficient supplies for the duration of their program? ☐ YES ☐ NO

If, NO, please elaborate on the plan to refill the prescription:

Are there any medication/s that the student is currently taking that they will not be taking during the HMI program? If so, please describe, noting the reason for medication termination.

Additional Information:

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If applicable, to be completed by parent/s and attached to the General Medical History & Information Form

Student Name **HMI Program** **Today's Date**

MENTAL HEALTH Related Medical History & Information Form

On your medical form, you noted past or present mental health issues. We ask a series of questions of any student who has a history of mental health issues because we can accommodate many issues when we have the proper information. Please complete the questionnaire below and return it to HMI as soon as possible. Responding as soon as possible and as thoroughly as possible will help us!

Does the HMI Student have: ☐ Depression ☐ Anxiety Disorder ☐ Addiction ☐ Suicide Attempt or Suicidal Ideation ☐ Cutting or other Self Abuse ☐ Other (explain):

When did symptoms first occur: When was the above diagnosed:

What were the symptoms and/or behaviors:

Has the student seen a counselor or therapist in the last two years?

Is the student currently seeing a counselor or therapist?

Counselor/Therapist Name: Counselor/Therapist Phone:

Under current treatment, how does the student's mental health issue manifest itself?

Does the mental health issue interfere with school and/or social interactions? If so, how?

Has the student ever had suicidal ideations or attempted suicide? ☐ YES ☐ NO If, YES, when?

During the last two years, has the student taken any medications for mental health issues? ☐ YES ☐ NO

Is the student currently taking any medications for mental health issues? ☐ YES ☐ NO (If YES, please complete the medications information form)

For stress related issues and/or mental health issues exacerbated by stress:

Making new friends & learning to function in a group can be stressful. With that in mind: What triggers stress for the student?

What can we do at HMI to help minimize stressful situation which may arise during the program?

Has the student ever been hospitalized for psychiatric illness? ☐ YES ☐ NO If yes, please explain when, for how long, and why. Be specific.

Additional Information:

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If applicable, to be completed by parent/s and attached to the General Medical History & Information Form

Student Name **HMI Program** **Today's Date**

ORTHOPEDIC Related Medical History & Information Form

On your medical form, you listed a history of orthopedic and/or athletic type injuries. We ask a series of questions of any student who has a past injury because we can accommodate many injuries when we have the proper information. Please complete the questionnaire below and return it to HMI as soon as possible. Responding as soon as possible and as thoroughly as possible will help us! Attach additional pages as necessary.

Injury: **When:**

How was the injury treated?

Did the student have physical therapy? ☐ YES ☐ NO If, YES, for how long and when:

Does the student still have pain as a result of this injury? ☐ YES ☐ NO

If YES, what causes the pain and for how long?

Does the student still have loss of function or disability as a result of this injury? ☐ YES ☐ NO

If YES, describe the disability, be specific.

Which description best describes the student's current condition: ☐ no longer a concern ☐ stable ☐ improving ☐ worsening

Since this injury, has the student played sports, carried a backpack, run or hiked for regular intervals? Be specific.

Is the student currently taking any medications for the above injury? ☐ YES ☐ NO (If YES, please complete the medications information form)

Do you anticipate the student being limited in his/her ability to participate in a physically demanding program? ☐ YES ☐ NO

If "YES", for what activities, and for how long?

If the injury occurred recently (within the last 6 months) or is persistent, please have the treating physician acknowledge that participation in an HMI program will not cause further damage or harm – have him/her review the activities on page 4 and note this on the medical form.

Injury: **When:**

How was the injury treated?

Did the student have physical therapy? ☐ YES ☐ NO If, YES, for how long and when:

Does the student still have pain as a result of this injury? ☐ YES ☐ NO

If YES, what causes the pain and for how long?

Does the student still have loss of function or disability as a result of this injury? ☐ YES ☐ NO

If YES, describe the disability, be specific.

Which description best describes the student's current condition: ☐ no longer a concern ☐ stable ☐ improving ☐ worsening

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