DPCA Ekklesia Mountain High Medical History and Information

PLEASE READ & REVIEW CAREFULLY!

Medical History & Information Review at Ekklesia Mountain High

Ekklesia Mountain High at Darren Patterson Christian Academy (EMH/DPCA) collects medical information to endeavor to provide more successful experiences and to assist in managing the risks faced by our students. EMH/DPCA's students will travel and experience a variety of risks, environmental conditions, physical difficulties, and access or lack of access to professional medical care both in the U.S. and travel abroad. Please review the EMH/DPCA Acknowledgment and Assumption of Risks & Release and Indemnity Agreement. If you or your physician have any questions concerning your child's ability to participate, please contact us. EMH/DPCA treats all personal medical information with some degree of confidentiality, meaning that enrolled student medical information is shared with the faculty, staff, and instructors who oversee the students on campus and in the backcountry but will remain confidential for other students and parents. All students must be medically approved as part of the final acceptance into the program.

Instructions for completing Medical Forms:

One or both of a student's parents or guardians must complete EMH/DPCA's Medical Forms. In the event that the student is 18 years of age he/she may complete these forms him/herself. Parents are encouraged to complete these forms with the students.

Be Honest: It is in everyone's best interest to disclose medical information upfront so EMH/DPCA obtains accurate information and understands the student's medical or health issues. This will provide the safest experience for the student. Failure to disclose such information could result in serious harm to the student and fellow participants. Our students are precious to us; help us provide the best care possible.

Be Thorough: Fill out the medical forms completely. Incomplete or blank answers will require EMH to contact you and may delay the enrollment process.

Questions and Information on Where to Send Completed Forms

Please direct all questions to Erik Ritschard, Head of School, or Jordan Euler, Lead EMH Instructor:

Emails: admin@dpcaweb.org, euler_j@dpcaweb.org, emhinfo@dpcaweb.org
School: 719 395 6046 Ext: 23
Cell: 719 221 3870

Send all completed forms to:

Darren Patterson Christian Academy
Attention: Erik Ritschard
PO Box 1243
Buena Vista, CO 81211

If you would prefer to fax the forms: 719 395 2055

If you would prefer to scan and email the forms: euler_j@dpcaweb.org, emhinfo@dpcaweb.org, or admin@dpcaweb.org

To Be Completed by Parent(s)

Student's Info

Full Name: _____ Date: _____ Birth Date (M/D/Y): _____Gender: _____Grade:____

Father's or Guardian Contact Info:

Full Name: _____ Day Phone: _____ Evening Phone: _____

Cell Phone: _____ Email Address: _____

Mother's or Second Guardian Contact Info:

Full Name: _____ Day Phone: _____ Evening Phone: _____

Cell Phone: _____ Email Address: _____

Dentists/Physicians Info:

Physicians Full Name: _____ Phone: _____

Address: _____City: _____ State: ____ Zip: _____

Date of Last Physical Exam: _____

Dentists Full Name: _____ Phone: _____

Address: _____City: _____ State: ____ Zip: _____

Date of Last Exam: _____

Medical History:

Please read each item/question carefully To the best of your knowledge, does your child have a history of or current problems with the following: Please check "yes" or "no" or N/A –not applicable and list the date for any of the "yes" answers.

Medical Illness/Issue:	Y	N	N/A	Date
Altitude: Acute Mountain Sickness				
Asthma				
Bleeding or Blood disorders				
Cancer				
Cardiac (Heart) Abnormalities or Problems				
Circulatory Problems				
Cold Injuries				
Chicken Pox				
Colitis/IBS				

Medical Illness/Issue:	Y	N	N/A	Date
Hepatitis				
Hormonal &/or Thyroid				
Hypertension				
Jaundice				
Kidney or Liver Diseases/Issues				
Leg Cramps				
Measles				
Meningitis				
Menstrual Cramps				

Medical Illness/Issue:	Y	N	N/A	Date
Dental Problems/Issues				
Diabetes **				
Ear, Eye, Nose & Throat Infections/Issues				
Eating Disorders (anorexia, bulimia, etc…)				
Epilepsy or Other Seizure Disorders**				
Eye or Vision (glasses/contacts)				
Fainting or Dizziness, chronic				
Fainting During Exercise**				
Gastrointestinal Tract, Ulcers				
Headaches, Concussions, Migraines				
Heat Injuries/Illness				

Medical Illness/Issue:	Y	N	N/A	Date
Mononucleosis				
Mumps				
Neurological Disorders				
Poliomyelitis				
Respiratory Tract (Chronic Cough)				
Rheumatic Fever				
Sickle Cell Anemia				
Skin Problems/Issues				
Sudden Death under age 50 of family member**				
Tuberculosis				
Other (Explain)				

**** If you answered "YES" to any of these questions, please call the school as a physician's release is REQUIRED for your admission to EMH/DPCA. Release forms are available from the school's office. Please submit a signed release form or signed doctor's note along with this medical disclosure form.** *For each "YES" answer from above, please fully explain the history, current status, and any other pertinent information:*

Immunization History: Record month and year of immunization

Type	First	Booster	Booster
DPT: Diptheria, Pertussis (Whooping cough), Tetanus			
Tdap: Tetanus, Diptheria, Pertussis			
Oral Polio (Sabin) TOPV			
Injectable Polio (SALK)			
MMR I & II (Measles, Mumps, Rubella)			
Other			
Tuberculin Test given__(most recent)			
Haemophilus Influenza b (HIB)			
Hepatitis B			
Varicella or Chicken Pox			

You have the right to have your child exempted from these immunizations based on:

- Medical Exemption: must be signed by a physician stating that the immunizations would endanger the student's life or health.
- Religious Exemption: must be signed by a parent or guardian stating religious belief opposed to immunization.
- Personal Exemption: must be signed by a parent or guardian stating personal belief opposed to immunization.

In the absence of a signed, bona fide exemption, an immunization record is required by law and must be complete.

Description of activities in which EMH/DPCA students will be involved:

EMH/DPCA's desire is to take students out of their comfort zones and to be stretched. We want to provide opportunities for students to grow deeper in their walk with Christ, to fully experience God's creation in all of its splendor, to grow in true community and discipleship, to mature, to become a servant leader, deepen their knowledge, and to understand the importance of physical exercise. Much of this "holistic growth" happens in the wilderness setting, and even though these experiences will be enjoyable and life changing, it will be physically strenuous and will test the student's physical resolve. There will be times that it will be difficult. Below is a list of possible experiences that a student might encounter during the EMH year. Our goal is not to make these experiences easy but to challenge the students to grow. Please read through them carefully and evaluate the student's physical, mental, and emotional current health.

- **Hike or ski 3-10 miles while carrying 35-60% of weight**
- **Hike, climb, and ski up and down steep terrain**
- **Sustained walking, hiking, running, carrying, and lifting**
- **Perform manual labor at Silver Cliff Ranch**
- **Participate in morning exercises**
- **Participate in meaningful, biblical discussions**
- **Be able to study and learn in wilderness setting**
- **Be willing to try new things**
- **Participate in a small, biblical community**
- **Travel to other countries**
- **Live and travel in rugged terrain which includes:**
- **Elevation ranging from 4,000 to 14,000 feet**
- **Sleeping in tarps, tents, and snow shelters**
- **Remote settings: 4-72 hours from advanced care**
- **Cooking meals for self and others**
- **Swimming, wading, and immersion in cold water**
- **Be alone during monitored solos for 2-48 hours**
- **Being out for up to 10 days at a time**
- **Be able to do a multi-pitch rock climb**

Considering the activities from the list above, list any concerns the students has that might affect his or her ability to participate in EMH/DPCA's activities.

_____
_____
_____
_____
_____
_____

Considering the activities from the list above, list any limitations the student has that would prevent him or her from fully participating in EMH/DPCA's activities.

_____
_____
_____
_____
_____
_____

Rate your fear of heights on a scale of 1-10; 1 being no fear and 10 being extreme terror_____

ATTACH Physical Form (either EMH's or your Health Care Provider's) to this form for submission. Each student must have had a physical completed within 12 months of the start of the program.

AUTHORIZATION FOR TREATMENT

This health history is correct to the best of my knowledge, and the person herein named has permission to engage in all EMH/DPCA activities except as noted. I hereby give permission to the EMH/DPCA staff, representatives, and/or other medical personnel to order X-rays, routine tests, treatment and to release (to or by EMH/DPCA) of any records necessary for treatment, referral, billing, or insurance purposes. In an emergency, I hereby give permission and authorize the physician selected by EMH/DPCA to secure or administer emergency medical treatment, including hospitalization and any other emergency medical procedures which may be needed for the person named herein. I authorize the physician or dentist to call in any necessary consultants in his/her discretion. It is understood that this consent is given in advance of any specific diagnosis or treatment being required, and is given to encourage those persons who have temporary custody of the minor, and said physician or dentist to exercise their best judgment as to the requirements of such diagnosis or medical, dental, or surgical treatment.

Student Name (printed): _____ **Student Signature** _____ **Date:**_____

Parent/Guardian Name (printed): _____ **Parent/Guardian Signature** _____ **Date:**_____

2nd Parent/Guardian Name (printed): _____ **2nd Parent/Guardian Signature** _____ **Date:**_____

I agree to remain fully liable and responsible for the payment of any such hospital, doctor, ambulance, dental, or medical fees. I further agree that in giving this permission and authorization, EMH/DPCA does not assume any responsibility or liability for the payment of such hospital, doctor, ambulance, dental, or other medical fees which may be incurred. The completed forms may be photocopied and maintained by authorized personnel for use in the field.

Student Name (printed): _____ **Student Signature** _____ **Date:**_____

Parent/Guardian Name (printed): _____ **Parent/Guardian Signature** _____ **Date:**_____

2nd Parent/Guardian Name (printed): _____ **2nd Parent/Guardian Signature** _____ **Date:**_____

Health Care Provider and Physical Form:

All students must have had a physical completed within 12 months of the start of the EMH program.

Please use the form below (or) use your health care provider's form for submission to EMH.

To the Medical Care Provider:
Ekklesia Mountain High at Darren Patterson Christian Academy provides a new approach to education by providing a more "holistic" approach to a student's growth. It seeks to provide experiences that help students grow in "body, mind, and spirit." A big part of this approach takes place in a wilderness setting. Students will undergo strenuous physical activities while being 1 to 72 hours from medical care. As you evaluate the student, please keep in mind the following activities as they will be a normal part of an EMH student's experience. If you have any concerns, please let us know.

Activities:

- **Hike or ski 3-10 miles while carrying 35-60% of weight**
- **Hike, climb, and ski up and down steep terrain**
- **Sustained walking, hiking, running, carrying, and lifting**
- **Perform manual labor at Silver Cliff Ranch**
- **Participate in morning exercises**
- **Participate in meaningful, biblical discussions**
- **Be able to study and learn in wilderness setting**
- **Be willing to try new things**
- **Participate in a small, biblical community**
- **Travel to other countries**
- **Live and travel in rugged terrain which includes:**
- **Elevation ranging from 4,000 to 14,000 feet**
- **Sleeping in tarps, tents, and snow shelters**
- **Remote settings: 4-72 hours from advanced care**
- **Cooking meals for self and others**
- **Swimming, wading, and immersion in cold water**
- **Be alone during monitored solos for 2-48 hours**
- **Being out for up to 10 days at a time**
- **Be able to do a multi-pitch rock climb**

Student Name: _____ Examination Date: _____

Height:	**Weight:**	**BMI:**	**Blood Pressure:**
Heart Rate (rest): _____ **Exercise: _____** **Recovery: _____** **Peripheral Pulses: _____**			
Pupils Equal or unequal:			
Eyes:	**Ears:**		**Nose:**
Throat:	**Teeth:**		**Skin:**
Lymphatic:	**Lungs:**		**Heart:**
Abdomen:	**Genitalia (males only)**		**Back:**
Cervical/spine/neck:		**Shoulder:**	
Hips/Thighs:		**Arm/elbow/wrist/hand:**	
Hip/thigh:		**Knee:**	
Leg/ankles:		**Feet:**	
Lab: urine_____ **hemoglobin/HTC_____** ***(when medically indicated)***			
Date of Last Tetanus Inoculation:	*Students need Tetanus Inoculation w/in last 10 years. If outdated, then please administer today.*		

Known Allergies &/or Dietary Restrictions:
Student under the care of a physician for the following:
Recommendations &/or restrictions regarding participation in the EMH program:
Treatment and medications to be continued at EMH for ongoing health issues &/or recent injuries/illness:
Additional health care considerations for EMH:

I have examined the student named on this form and understand he/she is planning to attend EMH/DPCA. I have reviewed all health, and medical information supplied in this form for its accuracy. I understand the nature of the activities, as set forth above and acknowledge that EMH/DPCA representatives are available should I have further questions about the nature and/or physical or emotional demands of these activities. I understand that the student will be traveling in remote areas where medical care may be significantly delayed. Considering any restrictions stated above, the student can, in my opinion, fully participate in the EMH/DPCA program. I am not related to the student.

Printed Name: _____ Title:_____ Date:_____

Signature **X**:_____ Clinic/Hospital Name & Address:_____

_____

Phone: _____ Mobile/Pager: _____

Email: _____

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

Form Name	Complete this form if:
❑ ALLERGY Form	Any student with any known allergies of any type must complete this form.
❑ ADD/ADHD Form	Any student with a past or current history of Attention Deficit Disorder and/or Attention Deficit and Hyperactivity Disorder must complete this form.
❑ MEDICATIONS Form	Any student who will be taking any medications while attending an EMH 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 EMH. 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.

Additional ALLERGIES Information Form: Fill out if the student has ANY known allergies.

Student Name: ____________________________ Date: ___________

Below is a series of questions to find out more specific information about each allergy. This will assure that we are most prepared in any given circumstance to deal with your student's allergy.

Allergy/Allergen: _________________________ Alternative/related/other names:__________________

When diagnosed with allergy:
How diagnosed to this allergen:
Symptoms during an allergic reaction (what happened?):
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 form) ☐ YES ☐ NO
Has the student ever been hospitalized for this particular allergy? (If YES explain in detail on separate sheets as necessary.) ☐ YES ☐ NO
Does the student have and carry epinephrine for this allergy? (If YES, the student must bring **two** delivery devices to EMH) ☐ YES ☐ NO
Additional Information:

Allergy/Allergen: _________________________ Alternative/related/other names:__________________

When diagnosed with allergy:
How diagnosed to this allergen:
Symptoms during an allergic reaction (what happened?):
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 form) ☐ YES ☐ NO
Has the student ever been hospitalized for this particular allergy? (If YES explain in detail on separate sheets as necessary.) ☐ YES ☐ NO
Does the student have and carry epinephrine for this allergy? (If YES, the student must bring **two** delivery devices to EMH) ☐ YES ☐ NO
Additional Information:

Allergy/Allergen: _________________________ Alternative/related/other names:__________________

When diagnosed with allergy:
How diagnosed to this allergen:
Symptoms during an allergic reaction (what happened?):
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 form) ☐ YES ☐ NO
Has the student ever been hospitalized for this particular allergy? (If YES explain in detail on separate sheets as necessary.) ☐ YES ☐ NO
Does the student have and carry epinephrine for this allergy? (If YES, the student must bring **two** delivery devices to EMH) ☐ YES ☐ NO
Additional Information:

Please attach additional sheets as necessary

Additional ADD/ADHD Information Form:
Fill out if student has suspected or diagnosed ADD/ADHD.

Student Name: _____ Date: _____

Below is a series of questions to find out more specific information. This will assure that we are most prepared in any given circumstance to deal with your student's learning challenges.

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

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? (If YES, please complete the Medications Form) ☐ YES ☐ NO
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?
Treating Counselor/Therapists/Physician's name: Treating Counselor/Therapists/Physician's Phone:
Additional Information:

Please attach additional sheets as necessary

Additional MEDICATIONS Form: Fill out if student takes ANY regular MEDICATIONS.

Student Name: _____ Date: _____

Below is a series of questions to find out more specific information about **EACH** medication the student is taking. We ask, that in consultation with your family physician, you please complete the following questionnaire regarding the student's medications and return it to us. This form will be kept on file with the other medical forms, and be used as a resource for all EMH/DPCA staff to better serve your student. We ask that you fill out a form for **EACH** medicine the student will be brining to EMH/DPCA including: prescriptions, over-the-counter medications, dietary supplements, herbal remedies, etc.
Note: EMH/DPCA has and provides regular over-the-counter medications for minor illness (headaches, cramps, cold & flu, sore throat, etc.) and ask that students do not bring them.

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 and symptoms) for dosing, if applicable (e.g. onset of shortness of breath):
This medicine 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 aspirin)
Indications or contraindications for use regarding: intensive sun exposure, altitude (5-14,000 ft.) rigorous exercise, cold/heat exposure?
Missed dose procedure: ☐ Skip dose ☐ Take immediately ☐ Double dose at next scheduled time ☐ call physician ☐ other:
What happens if student misses a dose?
Prescribing Physician's name: Prescribing Physician's Phone:
Will the student come to EMH with sufficient supplies for the duration of their program? ☐ YES ☐ NO
If NO, please eloborate 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 EMH/DPCA program? If so, please desribe, noting the reason for medication termination.
Additional Information:

Please attach additional sheets as necessary

Additional MENTAL HEALTH Information Form:
Fill out if has ANY history of MENTAL HEALTH issues, challenges, professional counseling, admittance to mental health facility, etc.

Student Name: _____ Date: _____

Below is a serious of questions to find out more specific information regarding the student's mental health. This will assure that we are most prepared in any given circumstance to deal with your student's mental health history.

Does the EMH student have: ❑Depression ❑Anxiety Disorder ❑Addiction ❑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? ☐YES ☐NO
Is the student currently seeing a counselor or therapists? ☐ YES ☐NO
Counselor/Therapists name: Counselor/Therapists 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 medications for mental health issues? ☐ YES ☐ NO
Is the student currently taking any medications for mental health issues? ☐ YES☐ NO (If YES, complete the medications form)
For stress related issues and/or mental health issues exacerbated by stress:
Making new friends and learning to function in a group can be stressful. With that in mind: What triggers stress for the student?
What can we do at EMH/DPCA to help minimize stressful situations which may arise during the program?
Has the student ever been hospitalized for psychiatric illness? ☐YES ☐NO
Additional Information:

Please attach additional sheets as necessary

Additional ORTHOPEDIC Information Form: Fill out if ANY history of ORTHOPEDIC or ATHLETIC injuries or trauma:

Student Name: _____ Date: _____

On the medical form, you listed a history of orthopedic and/or athletic type injuries. Below is a serious of questions to find out more specific information. This will assure that we are most prepared in any given circumstance to deal with your student's history of injuries.

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 disablity as a result of this injury ☐ YES ☐ NO
If YES, describe the disability, be specific.
Which description best describes the students 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 currentyl taking any medications for the above injury? ☐ YES ☐ NO (If YES, please complete the medications 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 the EMH program will not cause further damage or harm – have him/her review the activities on page 3 and have the physician sign off on the physical.

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 disablity as a result of this injury ☐ YES ☐ NO
If YES, describe the disability, be specific.
Which description best describes the students 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 currentyl taking any medications for the above injury? ☐ YES ☐ NO (If YES, please complete the medications 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 the EMH program will not cause further damage or harm – have him/her review the activities on page 3 and have the physician sign off on the physical.

Please attach additional sheets as necessary