SEEDS OF PEACE CAMP

Camper Health History Form C – Mental Health Professional

Camper First Name, Camper Last Name:

Instructions
To Mental Health Professional: Thank you for assisting us in the process of supporting youth in their summer journeys to Seeds of Peace Camp! Your patient has indicated that they are receiving mental health supports from you. We are asking for your input on if and how to best support your client in thriving in our Camp environment. All Seeds of Peace programs are rooted in dialogue, community, leadership, and action-taking. This summer, youth of different racial, religious, gender, and political identities will gather to live with and learn from one another in an outdoors residential Camp environment at the Seeds of Peace Camp in Maine. The program and activities include: participating in sports, arts, and swimming activities in an outdoor environment; sleeping in a rustic shared cabin with other youth and adult staff; utilizing shared bathroom and shower houses; participating in dialogue conversations about our identities, lived experiences, beliefs, and responsibilities with youth of different backgrounds; having limited access to phones and technology; walking between activities in an outdoor setting; eating meals in shared cafeteria with social distancing and/or outdoors under tent; maintaining COVID-19 protocols including wearing a mask during most activities outside of the camper's bunk. This document includes the mental health provider portion of the camper application. Please complete and return the form to camp@seedsofpeace.org as soon as possible. Thank you for your support. Seeds of Peace Camp Team camp@seedsofpeace.org

Camper Information
Camper First Name, Last Name _____
Camper Gender (circle one): Male / Female / Other (Please Describe:_____)
Diagnosis:

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How often have you seen this patient (in-person/virtual) over the past 12 months?

_____

Is your patient current taking prescription medication for this issue? □Yes □No

- □ I have reviewed the program activities above and my patient can safely participate in all programs and activities
- □ I have reviewed the program activities above and my patient can safely participate in all programs and activities with the following restrictions (please describe management plan below)
- □ I have reviewed the program activities above and my patient cannot safely participate in the Camp

Management Plan. If your patient can safely participate in programs and activities, please describe the patient's treatment/management regimen while at Camp.

Known Triggers and Decompensating Indicators

List situations that might be triggering for your patient, and behaviors that would indicate decompensating.

Additional Notes. Please add any additional information regarding your patient's well being and regulation of behavior:

Name of Mental Health Professional: _____

Email: _____ Phone Number: _____

Signed: _____

Date: _____