Mountain Spirit INSTITUTE

Office use Only

Adult Confidential Medical Record

Office Use Only

Follow-up
Approval

Complete both sides In full and return to:

Mountain Spirit Institute
POB 626
Sunapee, NH 03782
603-763-2668 FAX:: 630-604-9313

Program___ _____ Date _____

INSTRUCTIONS

Please fully complete and return this form as soon as possible in order to allow us adequate time for review and possible follow-up questions. We will determine the status of your participation after review of this form. Further evaluation may be needed by a physician in order for you to fully participate. If you choose to not proceed with the recommended follow-up, you will have the option of limited participation (based on your medical constraints). Please return the form, regardless of what choice you make.

NOTE: Most of our programs are structured to accommodate various levels of participation. You will be able to be fully interactive with your group at all times, regardless of your participation status.

PART I General Information

1	**Name:**	**2**	**Gender: Male ☐ Female ☐**
3	**Age: Birth date:**	**4**	**Social Security #:**
5	**Address: Apt. #**	**6**	**City/State/Zip:**
7	**Daytime Phone #:**	**8**	**Evening Phone #:**
9	**FAX #:**	**10**	**E-mail Address:**
11	**Emergency Contact:**	**12**	**Physician:**
	Relationship:		**Telephone #:**
	Daytime Phone #:		**FAX #:**
	Evening Phone #:	**13**	**Do you speak and understand English? Yes ☐ No ☐**
14	**Insurance Information:** *Each participant is responsible for any medical expenses and should be covered by his/her own sickness and accident insurance. The following questions must be answered for our insurance records.* **Note:** ***Please attach a photocopy of both front and back of your insurance card***		
	Insurance Company Name:		**Policy/Certificate #:**
	Prescription Plan #:		**Telephone #: (_____)_____**

PART II Medical Information

A. Allergies (Including allergies to medicines, foods, insect bites/stings) NONE ☐ or...

Allergy	Reaction	Medication Required (if any)

B. Current Medications (Including psychiatric and over-the-counter) NONE ☐ or...

Medication	Taken For: (Symptom/Condition)	Dosage	Date Started	Current Side Effects

Mountain Spirit Institute® requires participants to have a current tetanus immunization (booster within 10 years).

PART III Health Profile

#	Please √ one--If yes, describe below	Y	N	#	Please √ one--If yes, describe below	Y	N
1.	Seizure within the past 1 year			5.	Medical Device i.e. inhaler		
2.	Hospitalization / Emergency Room / Urgent Care visit within the past 1 year			6.	Neck / Back / Shoulder / Knee / Ankle or other orthopedic problem		
3.	History heart attack, by-pass/angioplasty/angina			7.	Currently Pregnant		
4.	Other cardiac conditions, e.g. heart murmur or other rhythm abnormality			8.	Other medical issues / illnesses / symptoms / requirements		

Item #	Describe
Item #	Describe

PART IV Cardiovascular Fitness Evaluation REQUIRED INFORMATION!

A. **Statistics / Vital Signs** We will be unable to evaluate you for participation in this program without this information.

Statistics	Vital Signs
Age:	*NOTE: Blood Pressure must be taken within 6 months of course start*
Height: Weight:	Blood Pressure _____/_____ Date Taken _____
Do you consider yourself to be overweight? . NO . YES If yes, by how much (approx.)? _____	*IF BP is over 150/90, please repeat:* Second Reading _____/_____ Date Taken _____ *BP may be taken with apparatus at local department or drug store*

B. Cardiovascular Risk Factors

Yes	No	Risk Factors
		High Blood Pressure, even if being treated with medication
		Smoker
		Diabetic requiring medication
		Known abnormally high cholesterol level or on a diet or medication for a lipid abnormality
		Family history (parent/sibling) of heart attack, coronary artery by-pass / angioplasty, or sudden, unexplained death ***before age 55***
		Unexplained chest pain/pressure, shortness of breath, heart palpitations, sweats/exertional dizziness/ faint spells

C. Current Exercise Activity (Needed as important assessment tool)

Please list the activities you engage in daily or weekly which indicate your current fitness level… Be sure to include activities such as walking a pet, mowing your lawn--or activities such as playing basketball. swimming, skiing, etc.

Activity	Frequency	Approximate Time / Distance	Leisurely	Moderately	Intensely

PART V Signature Required

I hereby apply to attend an MSI program and give permission for any emergency anesthesia, operation, hospitalization or other treatment which may become necessary.

All information will remain confidential. You should know that over the years, many students with a variety of medical/psychological difficulties have successfully completed our programs, but we must be aware of these conditions. Failure to disclose such information could result in serious harm to you and your fellow participants.

If you arrive at the program start with a pre-existing condition or injury that is not indicated on your medical form and you are subsequently forced to leave the program because of that condition, you will be charged an evacuation fee and will not receive a refund of tuition.

_____

Applicant's Signature **Date**