NAME OF APPLICANT: ______________________________

Date of Birth:______________________

UNITED SYNAGOGUE YOUTH

INTERNATIONAL SUMMER PROGRAMS

Mental Health Assessment Form

This form must be filled out by a licensed physician, psychiatrist, or psychologist if there is a CURRENT OR PAST history of a mental health condition such as but not limited to: *Anxiety, Depression, Bipolar disorder, Personality disorder, Executive function disorder, Autism spectrum disorder, Asperger's syndrome, Attention deficit disorder (ADD), Attention Deficit Hyperactivity disorder (ADHD), Anorexia/bulimia, or schizophrenia.*

Note to physician or mental health provider:

The patient who has provided you with this form has applied to participate in a comprehensive group teen summer travel experience. The program includes international travel to countries where *access to mental health providers will not be immediately available*. The days are comprehensive and long and include group participation in activities that include both physical and academic content as well as group communal living with shared eating and sleeping quarters. The patient has voluntarily disclosed a history of and/or current treatment of a mental health or psychological condition.

In order to ensure that this participant has a safe and successful summer travel experience, please assess this patient's psychological/psychiatric status by completing this **Mental Health Evaluation Form**. Please be aware that the more detail you provide, the better position our staff will be to fully evaluate the needs of this participant in the context of our summer travel program.

Release of Information:

I hereby authorize ____________________________(name of provider), to complete the follow Mental Health Assessment Form and share details of my/my child's medical/mental health history and treatment with United Synagogue Youth of United Synagogue of Conservative Judaism.

I understand that the information to be released is for the sole use of USY to assess my/my child's participation in USY summer programs.

This information may be disclosed to other health care or mental health providers as necessary to secure emergency treatment for my/my child if necessary. In addition it may be shared on a "need to know basis" with my/my child's group leader to better facilitate support for me/my child if needed.

I understand that this release of health information is voluntary on my part and this authorization may be revoked at any time by my written request.

Signature___________________________________ **Date**_______________

Patient / Guardian / Parent (circle one)

 NAME OF APPLICANT: ________________________________

Mental Health Assessment Form

Date of last assessment: (must be within 1 year) ________/_______/________.

School History:

School Performance – in and out of classroom

Usual grades: ☐Exceptional ☐Above Average ☐Average ☐Below Average ☐Failing

Has student been held back a grade? ☐Yes ☐No If yes, when:__________________________________

Has student ever been expelled from school? ☐Yes ☐NO If yes, why:__________________________________

Has student ever been qualified for special education: ☐ No ☐Yes If yes: grade____________________

Is student CURRENTLY receiving special education services: ☐No ☐Yes If yes: describe

____

Substance Use History: (Check all appropriate)

☐Unknown ☐ No Current or Past Substance Abuse ☐ Currently Clean & Sober for:☐>3 Months ☐>1 Year

Alcohol ☐Past ☐ Present specify:____

Drugs ☐Past ☐ Present specify:____

Mental Status (current): (Check and/or describe if abnormal or impaired)

Behavior/relatedness: ☐unremarkable ☐Inattentive ☐Impulsive ☐Hostile ☐Avoidant ☐Suspicious/guarded ☐Agitated ☐other:_____________

Mood/affect: ☐unremarkable ☐Depressed ☐Elated/expansive ☐Anxious ☐Labile/irritable

Thought process or insight and judgment: ☐unremarkable ☐Impaired__________________________

Comments:____

____

 NAME OF APPLICANT: ______________________________

Mental Health Assessment Form

Risk History(current): (Check all that apply)

☐Physical Abuse
☐Suicide Attempt
☐Assaultive Behavior
☐Inappropriate Sexualized Behavior
☐Witness to Domestic Violence
☐Sexual Abuse
☐Suicide Ideation
☐Self-injurious Behavior
☐Trauma or Loss in Family
☐Witness to Community Violence
☐Behavior Influenced by Delusions or Hallucinations
☐Other ____

Comments:____

____

Diagnostic Impression: (Check all that apply)

☐Anxiety ☐Attention Deficit Hyperactivity Disorder (ADHD) ☐Attention Deficit Disorder (ADD)

☐Depression ☐Bipolar ☐Personality Disorder ☐Mood disorder

☐Executive function disorder ☐Autism Spectrum Disorder ☐Asperger's Syndrome

☐Anorexia/Bulimia ☐Schizophrenia ☐Other ____________________________

Functional Impairment:

Family Relations	☐None	☐Mild	☐Mod	☐Severe
Peer Relations	☐None	☐Mild	☐Mod	☐Severe
School Performance	☐None	☐Mild	☐Mod	☐Severe

Treatment History (current and past year): (Check all appropriate and comment below)

☐Psych Hospitalization (dates: ________________) ☐Psychotherapy (dates: ________________________)

☐Substance Abuse Program (dates:_____________)

☐Psych Medication (past two years)

Medication Name	Dosage	Time(s) Given	Date started	Date Stopped
______________	_______	______________	____/____/_____	____/____/_____
______________	_______	______________	____/____/_____	____/____/_____
______________	_______	______________	____/____/_____	____/____/_____
______________	_______	______________	____/____/_____	____/____/_____
______________	_______	______________	____/____/_____	____/____/_____

Please use additional sheet if needed

 NAME OF APPLICANT: ______________________________

Mental Health Assessment Form

NOTE:

Psychological medications should be continued for the summer programs. The American Academy of Pediatrics has made a clear statement that "medication holidays" should be avoided in summer camp settings and our programs are no different. If a medication is helpful in one domain, such as school or home, it is also likely to be helpful for the summer program as well.

Physician/Psychiatrist/Psychologist Statement:

I have read the "notes to physician or mental health provider" on page one and have evaluated the applicant, __________________________________ within the past year.

1) I feel the applicant ☐IS ☐IS NOT psychologically stable to travel for an extended period of time on a teen summer program.

(IF NO:Explain____)

2) Is it my professional opinion that this applicant's psychological medication should be continued while on summer program? ☐YES ☐NO

(IF NO:Explain____)

PLEASE PRINT:

Name:	
Office address:	
Phone:	Date:

____ ______________________________________

Provider Signature **License Number and State of License**