THE SCHOOL FOR FIELD STUDIES

Psychotropic Medication Form

Participant Name _____

Program Location and Session _____

PART I: AUTHORIZATION: *- to be completed by Participant*

By my signature below, I hereby specifically authorize my physician, _____("Prescribing Provider"), of _____ (City, State) to release confidential patient information and/or medical records pertaining to myself, _____ ("Participant") to The School for Field Studies, Inc. ("SFS"), or its representative, to the extent necessary for the Provider to complete the foregoing form and to assess the appropriateness of SFS for the Participant at this time. Furthermore, I hereby expressly authorize the Provider to release such additional information as the Provider deems necessary or appropriate to respond to any additional questions SFS may have regarding whether SFS is appropriate for the Participant based on the release of information authorized by this form. I also give SFS permission to discuss this medical information with a medical consultant designated by SFS. I recognize that this information may be protected by state and federal regulations, and that I am hereby waiving such rights. I understand that I may revoke this authorization at any time (except retroactively), and, in any event, this authorization will expire automatically one year from the date signed.

Participant Signature:_____

Date _____

Please note: If your Provider requires a separate form for release of information and permission for further discussion, please complete those forms with your Provider.

PART I: PSYCHOTROPIC MEDICATION QUESTIONNAIRE: *- to be completed by the Prescribing Provider of any SFS student currently prescribed a psychotropic medication(s).*

GENERAL INFORMATION

Student/Client Name: _____ Date: _____

PROGRAM INFORMATION for PARTICIPANTS and MEDICAL PROFESSIONALS

Participants attending The School for Field Studies, Inc. (SFS) engage in rigorous academic programs while based at SFS's international field stations. These centers are rustic and remote. Because of their remoteness, and because programs often take place in developing countries, transportation to modern medical care is sometimes difficult and may take as long as 24 hours. Mental health counseling and other specialty medical services are not readily available.

SFS programs involve physically and often emotionally, rigorous conditions. There is limited personal time and personal space. The challenges participants may expect to experience include group living, academic deadlines, extreme climates, heat, sun, biting and stinging insects, swimming, strenuous physical activity, hiking, and field work in rugged terrain. Exposure to tropical and regional illnesses such as malaria, dengue, leishmaniasis, giardia, and others are possible. Prior physical conditioning is recommended, and a flexible and enthusiastic attitude is a necessity.

Please note that all SFS students a required to sign a release form giving permission for appropriate SFS personnel to conduct a medical review and approval prior to program participation, as well as to obtain any additional information necessary while the student is on program.

THE SCHOOL FOR FIELD STUDIES

MEDICATIONS

What medications is the student currently taking? Please fill in the chart below.

Medication	Condition	Dosage	Current/Potential Side Effects	Restrictions

QUESTIONS:

1. What specific symptoms or behaviors are being addressed by this medication(s)?

2. How long has the student been taking this medication(s) and is the dosage(s) stable? (Please note that SFS requires a four week adjustment period for any significant changes in psychotropic medications followed by the prescribing provider's evaluation prior to participation in an SFS program).

3. Will the medication(s) continue to be effective given the stresses of an SFS program?

THE SCHOOL FOR FIELD STUDIES

4. Does the student experience any side effects (i.e. dizziness, dehydration, etc.)? Please describe.

5. If the medication(s) were lost and could not be replaced within 24-72 hours, would there be a reason for concern?

6. Is there any additional information we should know?

May we contact you with further questions? **YES** **NO**

Prescribing Provider's Name (Please Print): _____

Medical Degree (Please Circle): M.D. D.O. P.A. R.N.P

Office Address: _____

Email Address: _____

Office Phone Number: _____ Office Fax Number: _____

Signature: _____ Date: _____

Please submit by fax to: 978-232-1254 "Attn: Safety Department" or by post mail to: The School for Field Studies, Attn: Safety Department, 100 Cummings Center, Suite 534-G, Beverly, MA 01915