COUNSELOR’S REPORT

*Only required if the student has been treated in the past 3 years by a mental health professional.

Student Participant’s Name: _______________________________________________________

NOTE TO THE COUNSELOR:

You are being asked to evaluate the above named applicant for participation in a four-month off-campus study program in the Adirondack Park. Mental health issues can be common for students transitioning into and living in a rural area. As you know, some mental health issues can also arise without a previous diagnosis. Likewise, living in unfamiliar surroundings and adjusting to social, cultural, and environmental differences can create emotional and physical stresses that might exacerbate mild disorders. Individuals in this program will oftentimes be in remote areas exposed to harsh environmental conditions, and away from immediate, full-service medical care. At the same time, the program site itself is endowed with a full spectrum of modern amenities—albeit located in a wilderness setting. And there are other amenities peppered throughout the Park. Please understand: the Adirondacks are a 6 million-acre patchwork of human settlements and true wilderness.

Students will spend the full semester living and working together on a 35-acre program site, as well as working out in the many hamlets and towns of the Park. The students will be expected to prepare and share meals and, at times, eat unfamiliar foods. This should be kept in mind for patients who have struggled with eating disorders. Similarly, patients with OCD or similar conditions might need to make significant adjustments to routine and lifestyle, both at the program site itself and throughout the varied field trips into the wilderness spaces of the Park.

For these reasons, we encourage all students to fully disclose their mental health history so that we may properly prepare them, and/or arrange for accommodations if necessary. In some cases, we may need to assess whether there may be health related reasons for students to consider participating in another program.

In order to insure this student’s well being, we ask you to describe fully any mental-health related history that could arise or be problematic for this individual in a largely rural setting. Please provide as much detail as possible that you judge may be helpful or required. The student has given permission for the release of all such information to the general director of the program, and, as may be necessary, the program’s faculty-in-residence, assistant dean of off-campus study, the medical director at Hamilton, and clinical staff at our counseling center.

PLEASE RETURN THIS REPORT TO:

Janelle A. Schwartz, General Director
Academic Program in the Adirondacks
Hamilton College
198 College Hill Road
Clinton, NY 13323
315-859-4054

Please contact the APA general director at 608-347-7886 with any questions or concerns.
1. Please describe the mental health condition for which this student is seeking or has sought counseling. Please include details of and precipitating event(s) and specific symptoms of this condition.

2. How was/is the condition being treated and for how long? Please include detail on the stability of the condition and recommendations for care.

3. Please list any medications prescribed for the condition being described.

4. Please list any triggers that might lead to the recurrence of this condition.

5. Please list coping strategies that the applicant has used for this condition in stressful situations.
   *If this student is currently in treatment/counseling, please work out a plan for this to continue prior to the student’s departure. We recommend arranging weekly Skype meetings or pairing the student with an appropriate resource in the Park. (We are happy to help with the latter.)*

6. What is a prescribed plan in the event that this condition becomes an acute emergency in the Adirondacks?

7. Are there any limitations to this applicant’s participation in emotionally or physically rigorous activities?

8. Would you recommend this student’s participation in the program? ☐ Yes ☐ No
   
   Comment: ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

Signature of Mental Health Care Provider: ____________________________ Date: ___/___/______

Name of Mental Health Care Provider (printed): ____________________________

Telephone: ____________________________ Fax: ____________________________