



**ANASAZI**  
**FOUNDATION**

the making of a walking

**ANASAZI Foundation**

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Mesa, AZ 85204

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SINJAAGUA



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## **Application and Admission Instructions**

This packet includes the application and confidential medical forms required for admission to ANASAZI Foundation's inpatient treatment program. These forms should be submitted with a comprehensive Social History (detailed in a separate document), which will be used to determine the appropriateness of placement. If you have questions about any portion of this packet, please contact ANASAZI's Admissions department at (480) 892-7403 or (800) 678-3445.

### **To apply for admission, please carefully review and complete the following steps:**

- Call the Admissions office and schedule an admission date.
- Send or fax the completed and signed admission forms, the completed Social History, and other requested information to the address below. If necessary, the forms may be signed in the ANASAZI office on admission day.
- Please include a recent color photograph of yourself and a copy of your immunization records with the admission forms.
- Follow the directions and use the relevant forms in this packet to obtain the required physical exam.
- Use the enclosed document titled Insights from Interested Parties if you wish to allow third parties (therapists, teachers, educational consultants, clergy, etc.) to share and receive information related to your treatment. (Optional)
- Contact a financial officer at ANASAZI to make financial arrangements.
- IMPORTANT:** Please have your parents/spouse accompany you on admissions day (Friday) to complete paperwork, attend the Program Overview orientation, and meet your therapist. Your parents/spouse are requested to participate in the 10-hour relationship seminar on the following day (Saturday) and a two-hour call on the following Wednesday. (See the course/call schedule included in this packet.)

### **Upon receipt of your application, we will:**

- Review your application and contact you with any further questions or requests.
- Request additional medical information, if necessary.
- Verify insurance coverage.
- Contact you for final financial arrangements.

**Please return materials to:**

**ANASAZI FOUNDATION  
1424 South Stapley Drive  
Mesa, AZ 85204  
480.892.6701 (FAX)**



## ADMISSION DAY – GUIDELINES AND AGENDA

Because this will be an important day, please be prepared to follow the guidelines below to help expedite the admissions process.

- Call our Admissions Director to schedule a time to arrive at our office (between 8:30 and 10 a.m.).
- Upon arrival, an ANASAZI TrailWalker will greet you at the door and guide you through the admissions process after you say goodbye to your family. Your parents and/or spouse will then meet with the Admission Director for a short orientation and with the Financial Officer for financial settlement.
- Once you and your TrailWalker have completed the admissions process, you will leave for the trail.

**Your parents and/or spouse are invited to attend the Program Overview orientation on Friday and a relationship seminar on Saturday.** This initial training ends with a follow-up conference call on the following Wednesday. The schedule for these days is as follows:

- *Program Overview (Friday, 12 to 2 p.m.)* Your parents/spouse will have an opportunity to meet with your therapist (Shadow) following this orientation.
- The *Seminar (Saturday, 8 a.m. to 6 p.m.)* is held upstairs in our Mesa office. Participation in this seminar is required if your parents/spouse wish to join you in the wilderness for the final three days/two nights of your stay at ANASAZI. Your family members should come casual and be ready to learn. The day will include numerous breaks, and they may leave the building for lunch. ANASAZI's enrollment fee includes the participation of two family members in the seminar. A materials fee of \$100 will be assessed for each additional family member wishing to attend.
- The *follow-up conference call (Wednesday, 5 to 7 p.m.)* is focused on the application of the ANASAZI principles at home.

**Suggested preparation for the Seminar:** Participants are encouraged to read *Leadership and Self Deception* and/or *The Anatomy of Peace* by the Arbinger Institute. They may purchase this book online through the ANASAZI Marketplace ([www.anasazi.org/store](http://www.anasazi.org/store)), at [www.arbinger.com](http://www.arbinger.com), or through a leading bookseller.

### Travel, Lodging and Conveniences

If you will be arriving by car, please see the map of the Phoenix/Mesa area located in the back of this packet. For more detailed directions, please contact the office in advance. Please know that freeway traffic is heavy in the morning.

If you will be arriving by airplane, please schedule your flights to the Phoenix Sky Harbor International Airport which is located approximately 20 minutes from the ANASAZI offices. Shuttles/taxis/rental cars are available at the airport.

There are many hotels located close to the ANASAZI offices. Please see the list in the back of this packet and remember to call ahead for reservations. Some hotels offer special rates for ANASAZI families.

**Discharge Schedule** (Your Shadow will provide you and your family with more details at a later date.)

- Tuesday your parents and/or spouse will arrive at the office at 8:00 a.m. for a brief review and orientation. They will then leave for the trail with an ANASAZI escort.
- Thursday you will return to the office for discharge. Discharge consists of meeting with Alumni Services and a brief exit interview. *Because we cannot guarantee your time of arrival back from the trail, please do not make flight arrangements until at least Friday.*



Dear Sinagua Participant;

We understand that seeking help for yourself can be very difficult, especially when the need falls into your life with urgency. With this in mind, we wish to do all we can to help simplify the enrollment process for you and your family. This letter will explain enrollment requirements, necessary preparations, and what you and your family will experience upon arriving at ANASAZI.

ANASAZI accepts new participants every Friday throughout the year. A limited number of new admissions are accepted for each session. Spaces are held on a first-come, first-serve basis determined by the receipt of enrollment packets and required deposit.

### **Enrollment Requirements and Screening**

Prior to acceptance for admission, the enrollment packet must be reviewed by our medical, clinical, financial and admissions departments. In determining whether ANASAZI is a good match for you, there are four key areas that we will review: family involvement, clinical appropriateness, medical soundness, and financial arrangements. The requirements for admission have been developed over years of experience. We consistently have found that exceptions compromise the quality of the ANASAZI experience.

#### **A. Family Involvement**

Much of the success of treatment at ANASAZI depends upon the commitment of your parents and/or spouse to be involved in your “walking”. Involvement includes:

##### **1. Orientation and Intervention Training**

We ask that your parents and/or spouse accompany you on the day of admission. While you prepare to go to the trail, your parents/spouse will attend an orientation and meet with your therapist (known as a “Shadow”). On the Saturday after admission, your parents/spouse will participate in an all-day seminar, and then call in for a two-hour, follow-up session the following Wednesday evening. The experience and information presented offer powerful tools which are vital to helping things go right when you return home. Your time on the trail is also the time for your parents/spouse to be learning, practicing, and implementing these new ideas, so they can help you sustain the changes made at ANASAZI. Other family members may attend the seminar at a discounted rate of \$100 per person.

##### **2. Letters**

We encourage family to write you at least weekly. Your family should send these letters by e-mail, postal service or fax so they arrive on Monday by 8 a.m. While on the trail, you will receive and send mail each Wednesday. Mail is restricted to family members unless you and your Shadow agree there are others who could assist in your progress.

##### **3. Weekly Sessions with Family Therapist/Shadow**

While you are on the trail, your family will participate in weekly sessions (via phone or in person, if possible) with your Shadow. These sessions serve two purposes. First, they offer a forum to discuss concerns, progress, challenges, and successes. Second, they help to further the ideas presented in the Saturday seminar and allow your parents/spouse to make changes at home. Your family's level of commitment and openness during these sessions will help to ensure you get the most from your experience on the trail and will build a stronger support system for when you return.



#### 4. DawnStar

Your parents and/or spouse are encouraged to spend the last three days and two nights of the program with you on the trail. At ANASAZI, we call this the DawnStar time. This offers a chance for parents and/or spouse to understand (in a small portion) the participant's experience, to allow you and your family time to resolve past issues and to set goals for the future. At the end of this tender and sacred time, the family returns together from the wilderness.

Please note that required hiking is minimal for parents and/or spouse, and we can be very accommodating to their health needs. We are also flexible in our ability to accommodate various family situations. Ideally, all parents and/or spouse will be involved in all aspects of the SinaguaWalker's experience. In all cases, at least one person is required. Seminars, phone calls, and DawnStar time can be staggered between family members.

### **B. Clinical Screening**

ANASAZI's clinical director will review the "Social History" portion of the enrollment packet to assess the appropriateness of placement and to match a Shadow with your family. ANASAZI cannot accept people who have displayed any extreme signs of violence or aggression, particularly outside the home, or those who have committed any sexual penetration.

### **C. Medical Screening**

In order to ensure the safety of participants in their ANASAZI Walkings, a careful medical screening is conducted prior to admission. ANASAZI's nurse will contact you (parents when necessary) before admission to discuss any medical concerns. Participation in the ANASAZI program should not be considered if any of the following conditions exist:

- History of seizures
- Diabetes
- Life-threatening allergies
- Severe (over or under) weight issues
- Other physical or medical conditions that interfere with hiking and camping

A physical exam is required within three (3) days prior to admission. The exam may be completed by your primary physician or ANASAZI's contracted physician on the day of admission. If you elect to have the exam completed on the day of admission, there will be an additional charge of \$205 for the physical. Our staff will transport you to the doctor's office or an urgent care facility for the exam.

ANASAZI maintains a restricted medication policy to ensure the safety and effectiveness of the program for each participant. Medications not permitted include those requiring refrigeration, blood-level monitoring and/or those with adverse side effects (i.e., affecting hydration, appetite or mental and/or emotional attentiveness) and those medicines that interfere with participant safety in a wilderness setting (i.e., backpacking on varying remote terrain, high or low temperatures, sun exposure, dry climate, changes in elevations, etc.). Approved medication must be accompanied by written doctors' orders.

**Note: Please do not wean yourself off restricted medications without the consent or direction of a licensed physician.**

The foods you will be eating in the field have been carefully selected and are approved by the Arizona Department of Health Services. The diet is composed of fiber, protein, fat, and complex carbohydrates with adequate amounts of dairy products, vegetables, and fruit.



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Due to the nature of our programs, scratches, cuts and even abrasions are commonplace, so a tetanus toxoid booster administered within the past five years is required.

**D. Financial Screening**

The program fee is \$425 per day. A nonrefundable admissions/outfitting fee of \$795 is also required. All financial arrangements are based on a 42-day stay and must be made prior to admission (this includes insurance pre-approval, client loans, scholarship, etc.). If your stay is extended beyond 42 days, the program fee is \$365 per additional day. The daily fees cover all program costs, but do not include transportation to and from the client's home and the ANASAZI office in Mesa, Arizona, parents' lodging, replacement of lost or inadequate personal items, medical treatment off the trail, or the physical exam on the date of admission. Please make all checks payable to ANASAZI Foundation.

We hope this letter and the enclosed materials will provide answers to your questions. Please contact me at (480) 892-7403 or (800) 678-3445 for any additional information.

Very truly yours,

Virginia Robinson  
Admissions Director

I have read and I understand the information in this letter.

\_\_\_\_\_  
Participant

\_\_\_\_\_  
Date



## Enrollment Form

**Proposed Enrollment Date:** \_\_\_\_\_ Date parents and/or spouse will be attending seminar: \_\_\_\_\_

**Participant's Name:** \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Work #: \_\_\_\_\_

**Spouse's Name** (if applicable): \_\_\_\_\_ Cell #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Birthplace: \_\_\_\_\_ Ethnic Origin: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Eye Color: \_\_\_\_\_

Adopted?  YES  No If adopted, when? \_\_\_\_\_ Religion: \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-Mail: \_\_\_\_\_ Cell #: \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-Mail: \_\_\_\_\_ Cell #: \_\_\_\_\_

**Referred by:** \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Any pertinent legal system involvement? If so please explain: \_\_\_\_\_

Court ordered?  YES  No Name of PO: \_\_\_\_\_ Phone: \_\_\_\_\_

Arriving from Home, Foster Care, Detention, Treatment Facility, Other? \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy, Group, or Certificate Number: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Phone: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Phone: \_\_\_\_\_



### Consent to Release Personal and Confidential Information

By signing this form, I/we am/are giving ANASAZI permission to use/disclose pertinent confidential information related to my/our health care. I/We hereby release ANASAZI from all liability that may arise from the release of the information requested to the below identified person(s), professionals, institutions or agencies. I/We understand that my/our records and my child's ("participant" herein) records are protected under various confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for by law.

Participant Last Name:	First Name:	M.I.:
Date of birth:	Approximate date(s) of treatment:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

#### To whom information may be released:

- Medical staff, and mental health staff assisting or associated with ANASAZI (to allow the treatment team to review all information needed to complete treatment).
- National accrediting and state licensing agencies that conduct reviews of ANASAZI (to allow accrediting and licensing agencies to review charts for compliance).

#### Emergency contact (not living with the participant):

Name: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_  
 Phone: \_\_\_\_\_

#### Participant's or responsible party's health insurance company (please specify):

Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_

#### Therapists, counselors, educational consultants, ecclesiastical leaders, and/or other helping professionals associated with the participant or participant's family (Please specify):

#1 Name: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_  
 Limitations (if any): \_\_\_\_\_ Phone: \_\_\_\_\_

#2 Name: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_  
 Limitations (if any): \_\_\_\_\_ Phone: \_\_\_\_\_

#### Other (Please specify):

Name: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_  
 Purpose of release \_\_\_\_\_ Phone: \_\_\_\_\_

I/We certify that this consent and release has been made freely, voluntarily and without coercion and the information given above is accurate to the best of my/our knowledge. I/We understand that I/we may revoke this authorization at any time except to the extent that action has already been taken to comply with it. If I/we am/are currently receiving treatment from ANASAZI, I/we understand that this consent will automatically expire in six months unless I/we express written revocation at an earlier date. If I/we am/are no longer receiving treatment from ANASAZI on the date of the signature, this consent will automatically expire 90 days from the date of signature unless I/we express written revocation at an earlier date. Any re-disclosure of information received by recipient is prohibited.

Participant's Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Legal Guardian \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Legal Guardian \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Consent for Emergency Medical Treatment of an Adult

Participant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F  
Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ Admit Date: \_\_\_\_\_  
Parent(s) Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Spouse Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I, \_\_\_\_\_ do hereby consent to any x-ray, examination,  
Name of Participant

Anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to

\_\_\_\_\_ under the general or special instructions of  
Name of Participant

\_\_\_\_\_ or physician named by ANASAZI, when the  
Name of Physician Telephone

need for such treatment is clear and when efforts to contact me are unsuccessful, whether such diagnosis or treatment is rendered at the office of a physician or at a licensed hospital.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage ANASAZI and said physician to exercise their best judgment as to the requirements of such diagnosis or treatment. This consent shall remain effective until the Participant is discharged from ANASAZI, unless sooner revoked in writing and delivered to said physician or the participant.

\_\_\_\_\_  
Participant Date ANASAZI Authorized Representative Date







## Client Rights, Limitations, and Exceptions

Participant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  M  F

Parent(s) Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Welcome to ANASAZI.

All Clients have the following rights:

1. To be treated with dignity, respect, and consideration;
2. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, diagnosis, or source of payment;
3. To receive treatment that:
  - a. Supports and respects the Client's individuality, choices, strengths, and abilities;
  - b. Supports the Client's personal liberty; and
  - c. Is provided in the least restrictive environment that meets the Client's treatment needs;
  - d. To use the Satellite phone to call the Suicide Prevention Center if needed, 1-866-205-5229.
4. Not to be prevented or impeded from exercising the client's civil rights unless the client has been adjudicated incompetent or a court of competent jurisdiction has found that the client is unable to exercise a specific right or category or rights.
5. To submit grievances to agency staff members and complaints to outside entities and other individuals without constraint or retaliation;
6. To have grievances considered by ANASAZI Foundation in a fair, timely, and impartial manner;
7. To seek, speak to, and be assisted by legal counsel of the client's choice, at the client's expense;
8. To receive assistance from a family member, designated representative, or other individual in understanding, protecting, or exercising the client's rights;
9. If enrolled by the Department or a regional behavioral health authority as an individual who is seriously mentally ill, to receive assistance from human rights advocates provided by the Department or the Department's designee in understanding, protecting, or exercising the client's rights;
10. To have the client's information and records kept confidential and released only as permitted under Department of Health Services R9-20-211A.3.and B
11. To privacy in treatment, including the right not to be fingerprinted, photographed, or recorded without consent, except:
  - a. For photographing for identification and administrative purposes, as provided by A.R.S. § 36-507(2);
  - b. For a client receiving treatment according to the A.R.S. Title 36, Chapter 37;
  - c. For video recordings used for security purposes that are maintained only on a temporary basis; or
  - d. As provided in R9-20-602 A.5
12. To review, upon written request, the client's own record during the agency's hours of operation or at a time agreed upon by the clinical director, except as described in R9-20-211 A.6
13. To review the following at ANASAZI Foundation or at the Department of Health Services:
  - a. The report of the most recent inspection of the premises conducted by the Department, on premises in the possession of the Human Resources Director;
  - b. A plan of correction in effect as required by the Department;
  - c. If ANASAZI Foundation has submitted a report of inspection by a nationally recognized accreditation agency e.g., (The Joint Commission.) in lieu of having an inspection conducted by the Department, the most recent report of inspection conducted by the nationally recognized accreditation agency, on premises in the possession of the Human Resources Director;

- d. If ANASAZI Foundation has submitted a report of inspection by a nationally recognized accreditation agency in lieu of having an inspection conducted by the Department, a plan of correction in effect as required by the nationally recognized accreditation agency, on premises in the possession of the Human Resources Director;
14. To be informed of all fees that the client is required to pay and of the agency's refund policies and procedures before receiving a behavioral health service, except for a behavioral health service provided to a client experiencing a crisis situation;
15. To receive a verbal explanation of the client's condition and a proposed treatment, including the intended outcome, the nature of the proposed treatment, procedures involved in the proposed treatment, risks or side effects from the proposed treatment and alternatives to the proposed treatment;
16. To be offered or referred for the treatment specified in the client's treatment plan;
17. To receive a referral to another agency if ANASAZI Foundation is unable to provide a behavioral health service that the client requests or that is indicated in the client's treatment plan;
18. To give general consent and, if applicable, informed consent to treatment, refuse treatment or withdraw general or informed consent to treatment, unless the treatment is ordered by a court according to A.R.S. Title 36, Chapter 5, is necessary to save the client's life or physical health, or is provided according to A.R.S. § 36-512;
19. To be free from:
  - a. Abuse, neglect, exploitation, coercion, manipulation, retaliation for complaints filed with Department of Health Services or another entity;
  - b. Discharge or transfer, or threat of discharge or transfer, for reasons unrelated to the Client's treatment needs, except as established in a fee agreement signed by the Client or the Client's parent, guardian, custodian, or agent;
  - c. Treatment that involves:
    - 1) The denial of food, the opportunity to sleep, or the opportunity to use the toilet; and
    - 2) Restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation;
  - d. Any behavioral management and treatment intervention by another Client.
20. To participate or, if applicable, to have the Client's parent, guardian, custodian or agent participate in treatment decisions and in the development and periodic review and revision of the Client's written treatment plan;
21. To control the client's own finances except as provided by A.R.S. § 36-507.5
22. To participate or refuse to participate in religious activities;
23. To refuse to perform labor for ANASAZI Foundation, except for housekeeping activities and activities to maintain health and personal hygiene;
24. To be compensated according to state and federal law for labor that primarily benefits the agency and that is not part of the client's treatment plan;
25. To participate or refuse to participate in research or experimental treatment;
26. To give informed consent in writing, refuse to consent, or withdraw written consent to participate in research or treatment that is not a professionally recognized treatment;
27. To refuse to acknowledge gratitude to the agency through written statements, other media, or speaking engagements at public gatherings;
28. To receive behavioral health services in a smoke-free facility, although smoking may be permitted outside the facility; and
29. If receiving treatment in a residential agency, an inpatient treatment program, a Level 4 transitional agency, or a domestic violence shelter;
  - a. If assigned to share a bedroom, to be assigned according to R9-20-405 F and, if applicable, R9-20-404 A.4.a
  - b. To associate with individuals of the client's choice, receive visitors, and make telephone calls during the hours established by the licensee and conspicuously posted in the facility, unless:
    - i. The medical director or clinical director determines and documents a specific treatment purpose that justifies restricting this right;
    - ii. The client is informed of the reason why this right is being restricted; and
    - iii. The client is informed of the client's right to file a grievance and the procedure for filing a grievance
  - c. To privacy in correspondence marked confidential, communication, visitation, financial affairs, and personal hygiene, unless:
    - i. The medical director or clinical director determines and documents a specific treatment purpose that justifies waiving this right; and



- ii. The Client is informed of the reason why this right is being waived; and
  - iii. The Client is informed of the client's right to file a grievance and the procedure for filing a grievance;
  - d. To send and receive uncensored and unopened mail, unless restricted by the court order or unless:
    - i. The medical director or clinical director determines and documents a specific treatment purpose that justifies restricting this right;
    - ii. The client is informed of the reason why this right is being restricted; and
    - iii. The client is informed of the client's right to file a grievance and the procedure for filing a grievance;
  - e. To maintain, display, and use personal belongings, including clothing unless restricted by court order or according to A.R.S. § 36-507.5 and as documented in the client record;
  - f. To be provided storage space, capable of being locked, on the premises while the Client receives treatment;
  - g. To be provided meals to meet the Client's nutritional needs, with consideration for Client preferences;
  - h. To be assisted in obtaining clean, seasonably appropriate clothing that is in good repair and selected and owned by the Client;
  - i. To be provided access to medical services, including family planning, to maintain the Client's health, safety, or welfare;
  - j. To have opportunities for social contact and daily social, recreational, or rehabilitative activities; (Will have no access to telephones, recording, CD players);
  - k. To be informed of the requirements necessary for the Client's discharge or transfer to a less restrictive physical environment;
  - l. To receive, at the time of discharge or transfer, recommendations for any treatment needed when the Client is discharged.
30. To have a copy of the Behavioral Health rules described by R6-5-7440 (C)(4) made available.

If you have questions about treatment policies, please call the following regulatory agencies:

JOINT COMMISSION	800-994-6610
OFFICE OF BEHAVIORAL HEALTH	602-364-4558
CHILD PROTECTIVE SERVICES	888-767-2445

My signature denotes I have received and understand this policy.

\_\_\_\_\_  
Participant

\_\_\_\_\_  
Date



## Grievance Procedure - Client or Families

Policy Number: CLT 505

This policy is to provide Clients and/or families with a means to grieve alleged violations through a four-step grievance procedure. Clients and/or their families are encouraged to utilize the organization's Grievance Procedure prior to consulting with external organizations about the grievance within 60 days of admission to the program. Conversely, external organizations are encouraged to refer the Client and/or families to ANASAZI FOUNDATION to utilize their Grievance Procedure prior to involvement by an external organization.

PROCEDURE: At any step in this procedure, the Client may request the assistance in presenting the problem.

- Step I: When a problem arises, the Client is encouraged to address/resolve that difference with the Therapist/Shadow. In the event the problem is with the Therapist/Shadow and cannot be resolved; the Clinical Director should be notified. If the Client does not receive a prompt answer or is not satisfied with the answer, Step II may be initiated.
- Step II: To initiate this part of the procedure, the Client should contact the Clinical Director. The Clinical Director will respond to the grievance in writing within seven working days from the receipt of the grievance. If the Client is not satisfied with the response, Step III may be initiated.
- Step III: At this level the Clinical Director will arrange a meeting between the Administrator, the complainant, and anyone who may have been involved. The Administrator will respond in writing within seven working days from the first meeting.
- Step IV: Grievances unable to be resolved by the Administrator may be submitted to one or all of the following:

<b>The Joint Commission</b>	email: <a href="mailto:complaint@jcaho.org">complaint@jcaho.org</a> or	800-994-6610
<b>Office of Behavioral Health Licensure</b> , 150 N. 18 <sup>th</sup> Ave, #410, Phoenix, AZ 85007		602-364-2595
<b>Division of Behavioral Health Services</b> , 150 N. 18 <sup>th</sup> Ave. 2 <sup>nd</sup> Floor, Phoenix, AZ 85007		602-364-4558
<b>DHS – Office of Human Rights Advocates</b> , 150 N. 18 <sup>th</sup> Ave. 2 <sup>nd</sup> Floor, Phoenix, AZ 85007		602-364-4585
<b>Adult Protective Services</b> , 1789 W. Jefferson Street, Site Code 950A, Phoenix, AZ 85007		877-767-2385
<b>Child Protective Services</b> , P.O. Box 44240, Phoenix, AZ 85064		888-767-2445

My signature denotes I have received and understand this policy.

\_\_\_\_\_  
Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Spouse

\_\_\_\_\_  
Date



## Admission Agreement

Participant's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Date of Admission: \_\_\_\_\_

County & State of Execution: Maricopa, Arizona

Participant: \_\_\_\_\_ Parent / Sponsor: \_\_\_\_\_

Street: \_\_\_\_\_ Street: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Birth Date: \_\_\_\_\_

(COLLECTIVELY, THE "SPONSOR")

ANASAZI FOUNDATION  
An Arizona Non-Profit Corporation  
1424 S. Stapley Dr.  
Mesa, AZ 85204

("ANASAZI")

### Part 1 Sponsor

**1.1** Sponsor. Sponsor constitutes any person or persons who are financially responsible for the participant's participation in ANASAZI programs.

**1.2** Individual sponsor authority. If the sponsor consists of more than one person, any of the persons constituting the sponsor shall have the right individually to consult with and direct ANASAZI in connection with the progress of the participant, and ANASAZI shall be entitled to rely on the representation or authorization of any one of the persons constituting the sponsor with respect to the participant.

### Part 2 Admission

**2.1** Admission to program. Upon the execution of this agreement, ANASAZI agrees to accept the participant into the ANASAZI program selected by the sponsor, and ANASAZI agrees to provide the participant with a wilderness experience consistent with the ANASAZI program in which the participant is enrolled.

**2.2** Sponsor support. Sponsor understands and acknowledges that family support is essential for the success of the program, and sponsor agrees to support the participant's activities in the ANASAZI program. Sponsor is invited and encouraged to attend the parent seminar, "A Seminar on Relationships," to complete requested assignments, to spend the prescribed nights on the trail with the participant, and to cooperate with the ANASAZI personnel in working towards a successful completion of the program by the participant.

**2.3** Program completion. All participants accepted for the enrollment are accepted on the condition that they will complete the entire program. The sponsor agrees that the participant shall continue in the program chosen until the completion of the program by the participant, as determined in the judgment of the ANASAZI program director, unless either party terminates this agreement by giving written notice to the other party as outlined below.

### Part 3



## Consent and authorization

**3.1 Program participation: release.** The sponsor understands that participation in the ANASAZI programs involves strenuous physical activities as well as exposure to potentially dangerous wilderness situations. The sponsor hereby consents to the participant to engage in all of the activities of the ANASAZI experience. The sponsor hereby releases ANASAZI from any liability for any injury, illness, loss, cost, expense or other damage to the participant resulting from the involvement of the participant in the ANASAZI program.

**3.2 Medical treatment.** In the event of an injury, accident, illness, or other necessity, sponsor hereby authorizes ANASAZI to obtain medical and hospital care and to authorize a physician to perform any procedures, including surgery, administering anesthesia, or any other procedures that may be medically necessary for the well-being of the participant. The sponsor agrees to pay and to indemnify and hold ANASAZI harmless from all costs and expenses incurred in connection with such medical or hospital care.

**3.3 Personal search: contraband.** Sponsor hereby consents to and authorizes ANASAZI to search the personal effects and person of the participant, and to confiscate any and all items not on the approved equipment list, which items shall be deemed to be contraband. All confiscated items shall be delivered to the sponsor, and the disposition of all contraband items shall be the sole responsibility of the sponsor.

**3.4 Medical examination and drug screening.** Sponsor hereby consents to and authorizes ANASAZI to administer a routine physical examination and urinalysis drug test to the participant at any time during the program that is deemed necessary by ANASAZI.

## Part 4

### Financial obligations

**4.1 Basic charges.** The program fee is \$425 per day. A nonrefundable admissions fee of \$795 is also required. On the date of this agreement, sponsor shall pay all charges unless, other arrangements are agreed upon by both parties in writing prior to admission. All fees are considered to be earned upon admission. The sponsor bears full financial responsibility for all charges and expenses incurred, whether or not all or a portion of those charges or expenses are anticipated to be paid by a third party.

**4.2** When there is any deviation to the program structure, i.e. emergency admissions, additional trips to and from the trail at the sponsors request, etc an additional fee of \$1500 is required per event.

**4.3 Transportation and personal expenses.** In addition to the above payment, sponsor agrees to pay for all costs and expenses of (a) transportation of the Participant from the Participant's home to the ANASAZI office in Mesa, Arizona, (b) transportation from the ANASAZI facility in Mesa, Arizona to the Participant's home, (c) all medical and hospital expenses including the physical exam charges in case the sponsor decides to have the physical done by ANASAZI's contracted doctor on the day of admission, and (d) any required personal items required for Participants on the equipment list.

**4.4 Damage to property.** Sponsor agrees to pay for the costs of repairing any property belonging to ANASAZI, other Participants or other parties which is damaged, defaced, or destroyed by the Participant. ANASAZI is not responsible for the loss, damage, or destruction of any of the Participant's personal property.

**4.5 Runaway expenses.** In the event the Participant attempts to leave the program and becomes a runaway from ANASAZI, ANASAZI will use reasonable efforts to assist the sponsor in finding the Participant and in obtaining the safe return of the Participant to ANASAZI, but ANASAZI assumes no responsibility for the health or safety of the Participant during the time the Participant is absent from the program. The sponsor will be responsible for one-half (1/2) of all expenses incurred where the Participant runs away during the program, ANASAZI shall prepare an accounting of the expense incurred while assisting the sponsor in finding and returning the Participant to ANASAZI. The sponsor will be responsible for the full amount of expenses incurred where the Participant runs away prior to admission to the program.

**4.6 Rate for extended services.** In the event the Participant's stay extends beyond 42 days, sponsor agrees to pay a reduced program fee of \$365 per day (\$2,555 per week) for the remainder of the stay. Sponsor also agrees to pay for all additional expenses related to the extension.



**Part 5**  
Termination

**5.1** Termination by ANASAZI. ANASAZI reserves the right to terminate this agreement at any time due to illegal, uncontrollable, or dangerous action by the participant, unreported or previously unknown medical conditions, prior injuries or for any other reason whatsoever if deemed necessary by ANASAZI to ensure the safety or welfare of the participant or of other participants, staff or other persons affected or potentially affected by the participant. At the sole discretion of ANASAZI, the participant may attend a subsequent expedition if the condition which caused the participant's termination from ANASAZI no longer exists.

**5.2** Termination by sponsor. The sponsor has the right to withdraw the participant from the program at any time prior to completion, upon written notice.

**5.3** Liquidated damages. In the event of a termination prior to completion by either ANASAZI or the sponsor, the parties agree that the sponsor shall not be entitled to a refund of any amounts paid, nor shall there be a reduction in the obligation for basic charges or other expenses due from the sponsor. In the event the participant is removed from the program prior to the completion of the program, the non-refundability of payments made and the continuing obligation to pay any amounts due but not paid, reflects the recognition that certain costs associated with making the program available to the participant are incurred, whether or not the program is completed, including such items as salaries, inventories, and other general operating expenses. An allocation of actual costs incurred prior to termination is difficult or impossible to determine. Accordingly, the parties agree that the payment of the basic charges and other expenses due pursuant to this agreement are a reasonable estimate of the costs associated with the admission of the participant to the program, regardless of whether the program is completed or terminated, and are hereby agreed to constitute liquidated damages, and neither party shall have the right to any additional compensation or reimbursement in the event of a termination of the participant in an ANASAZI program.

**Part 6**  
Miscellaneous

**6.1** Cost of collection: attorney's fees. The sponsor agrees to pay the cost of collection of any amounts due under this agreement, including reasonable attorney's fees.

**6.2** Jurisdiction: applicable law. The sponsor agrees to be subject to the jurisdiction of Arizona courts in any dispute between parties to this agreement. Moreover, the parties agree that the Arizona law shall govern this agreement.

**6.3** No waiver. Failure of either party to enforce any term or provision of the agreement shall not constitute or be construed as a waiver of such term or provision or the right to enforce it, if any provision of the agreement is construed to be overbroad as written, the remaining provisions shall remain enforceable according to applicable law.

**6.4** Disclaimer: Sponsor acknowledges and understands that ANASAZI has made no representations or warranties with respect to the results which may be achieved from the participant's admission to the ANASAZI program. The complex makeup of each individual person combined with the extremely complex interpersonal relationships in a family make it impossible to predict or to guarantee any specific results from the ANASAZI programs.

**6.5** Entire agreement. Sponsor and ANASAZI hereby acknowledge that this agreement constitutes the entire agreement between the parties; any amendments or supplementary material shall not be enforceable unless in writing clearly referring to this agreement and signed by the parties or their duly authorized representatives.

In witness whereof, the parties have executed this agreement as of the effective date stated above.

\_\_\_\_\_  
Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Sponsor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Representative of ANASAZI

\_\_\_\_\_  
Date



## Insights from Interested Parties

This form should be given by parents/guardians to professionals (therapists, teachers, educational consultants, clergy, etc.) who may have information that would be helpful to ANASAZI.

Participant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M / F  
Completed By: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Relationship to Participant: \_\_\_\_\_

**Please provide any information that may be helpful in the treatment and care of the above named Participant.**

Presenting Concerns (at home, school, church, etc.)

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Developmental History (physical, educational, emotional, spiritual, etc.)

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Response to Interventions (guidance, advise, counsel, etc.)

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I give permission to the person I have asked to complete this form to share and receive information related to my treatment at ANASAZI.

\_\_\_\_\_  
Participant

\_\_\_\_\_  
Date



## Physical Examination, Blood Test, Prescriptions, and Current Tetanus Vaccination

Prior to enrollment in the ANASAZI Foundation, each participant must have a physical exam within one week of admission. This physical can be completed by a Physician (MD), Doctor of Osteopathy (DO), Nurse Practitioner, or Physician's Assistant (primary care practitioner) before admission or by a physician in Mesa, Arizona, as part of our admission process. The following must be submitted to ANASAZI for participation clearance into the program:

1. Completed Physical Form
2. Completed Required Blood Work
3. Completed Physician's Order Form for PRN (as needed) Medications
4. Any additional Prescriptions (from approved list of medications)
5. Immunization Records (You will provide this directly to Admissions Director)

### If obtaining physical BEFORE arriving at ANASAZI:

The physical exam must be performed by a licensed primary care practitioner who is informed as to the physical demands of participating in ANASAZI (i.e. backpacking and hiking from 5 to 20 miles per week, while carrying a 30-40 lb. pack, in various wilderness terrains, in a variety of elevations and temperatures with sun exposure, primitive living conditions, etc.)

Please give your written consent to your primary care practitioner to **immediately** fax the physical, lab results, and prescriptions to ANASAZI at 480.892.6701 for the Client's continued participation (**Consent form on following page**).

### If obtaining physical on DAY OF admission:

If you would prefer the physical be conducted on the day of admission, please ask the Admissions Director to schedule the exam with ANASAZI's contracted physician. Our staff will transport you to the doctor's office for the exam.

There will be an additional charge of \$205 for the physical. Participants must also have a current TB test (included if physical performed on admission day) and tetanus vaccine (\$35 if administered by ANASAZI's contracted provider). Please make checks payable to ANASAZI Foundation.

ANASAZI may require an additional blood test upon enrollment or during enrollment to verify detoxification or weaning is complete.

If you have any questions about the physical exam, please call the Admissions Director at 800.678.3445 or email [info@anasazi.org](mailto:info@anasazi.org).

### Check one to indicate your plans:

\_\_\_\_\_ Physical exam to be completed on the day of admission. The cost for the physical (includes TB test and drug screen) is \$205. If necessary, please add \$35 for tetanus vaccine.

\_\_\_\_\_ Physical exam will be completed by Client's primary care practitioner prior to admission day. Primary Care Practitioner will fax exam results to ANASAZI prior to admission day. Lab results to be faxed to ANASAZI as soon as completed at 480.892.6701.



## Consent for Release of Confidential Medical Information

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_  
Name of Parent/Guardian or Patient if over 18 Name of Practitioner or Medical Practice

to disclose to ANASAZI Foundation the following information regarding \_\_\_\_\_  
Name of Participant in ANASAZI Program

- a. Physical examination including urine dipstick
- b. TB and blood tests (including, but not limited to: Tetanus Toxoid, Serum Pregnancy Test, Drug Screen, CBC, CMP)
- c. Copy of immunization records
- d. Copies of current prescriptions currently being taken

The purpose of the disclosure authorized herein is to ensure appropriateness of wilderness treatment program and to ensure safety of the above-named participant while enrolled in wilderness treatment program.

Signature of Parent/Guardian or Patient if over 18 \_\_\_\_\_

Date: \_\_\_\_\_

### Instructions to Practitioner/Medical Practice

1. Complete physical form.
2. Complete required blood work (or make arrangements to have drawn at lab).
3. Complete Physician's Order form for PRN medications.
4. Fill out any additional prescriptions and please fax to the Apothecary Shop at 480-633-6974.
5. Fax results of physical, blood work, and prescriptions to ANASAZI Foundation at 480-892-6701.

# Physical Examination Form

Name of Client: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_  
 Lab: Urinalysis (Dipstick) Albumin: \_\_\_\_\_ Sugar: \_\_\_\_\_  
 Vision: Normal  \_\_\_\_\_ Glasses  \_\_\_\_\_ Contacts  \_\_\_\_\_  
 Hearing: Normal  \_\_\_\_\_ Abnormal  \_\_\_\_\_

**BLOOD LAB WORK RESULTS**  
 (Required – FAX to 480.892.6701)

Tetanus Toxoid (5 yrs): \_\_\_\_\_ Pregnancy Test (Urine): \_\_\_\_\_ CBC: \_\_\_\_\_  
 CMP: \_\_\_\_\_

	Normal	Abnormal Findings	Initials*
<b>Medical</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<b>Musculoskeletal</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand			
Hip/thigh			
Knee			
Leg/ankle			
Foot			

\*Station-based examination only

**Client plans to participate in physical activities including backpacking and hiking 5 to 20 miles per week, while carrying a 30-40 lb. pack, over a six week or longer period in remote areas, in a variety of terrains, temperatures and elevations.**

**CLEARANCE:**

- Cleared to Participate.
- Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_

**Recommendations:** \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ MD / DO / DC / NP / PA

Accompanied by: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

**Confidential & Privileged**  
 Professional use only.  
 Not to be published,  
 released or shared without  
 written permission.

## Tuberculin Skin Test

Client's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

\*\*\*\*\*

Date test administered: \_\_\_\_\_ Injection site: L R Forearm

Administered by: \_\_\_\_\_

Date results read: \_\_\_\_\_ Results read by: \_\_\_\_\_

Results (must be reported in millimeters):

Negative \_\_\_\_\_ mms Induration (Negative: 0-5mms)

Positive \_\_\_\_\_ mms Induration (Positive: 6+ mms)

\*\*\*\*\*

Chest X-Ray:

Date Performed: \_\_\_\_\_ Results: \_\_\_\_\_

## Physician's Order

Client's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

**PRN Medications** may be provided for pain, fever, insect bite, stings, respiratory allergies, hay fever, allergic reactions, minor skin irritations, minor cuts, scrapes, rashes, burns, stuffy nose, anaphylaxis, severe allergic reactions, cough, sore throat, mouth pain, minor throat irritations, asthma, or as determined otherwise by RN working with Physician.

Ibuprofen 400 mg PO every 4 hours PRN pain / swelling / fever.

Ibuprofen 800 mg PO every 8 hours PRN pain / swelling / fever.

Diphenhydramine 25-50 mg PO every 4 hours PRN insect bite / stings / upper respiratory allergies / allergic reaction / hay fever.

Bismuth Subsalicylate 262 mg PO two tablets every 6 hours PRN upset stomach / heartburn / indigestion / diarrhea / nausea.

Bacitracin Zinc ointment apply topically to cleaned affected area 1 to 3 times daily PRN minor cuts / scrapes.

Hydrocortisone cream 1% apply to cleaned affected area 3 to 4 times daily PRN itching/ minor skin irritations / rashes.

Sodium Chloride 0.9% 1L IV bolus PRN severe dehydration.

Epinephrine (adrenaline), epipen 1:1000, 0.3 ml (0.3 mg) IM lateral mid thigh may be repeated every 5 to 20 minutes as needed for severe allergic reaction / anaphylaxis / status asthmaticus. Client will be evacuated and evaluated by physician if this medication is used.

**Current active orders** (Please **attach the prescription(s)** for order by ANASAZI Staff):

Prescription	For Treatment of	Dosage
_____	_____	_____
_____	_____	_____

Change Orders: (Please **attach the prescription(s)** for order by ANASAZI Staff)

\_\_\_\_\_  
\_\_\_\_\_

### CLEARANCE:

- Cleared to use ALL PRN medications
  - Cleared to use ALL PRN medications **except:** \_\_\_\_\_
  - PRN medications NOT cleared: Reasons: \_\_\_\_\_
- \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ M.D. /D.O. / DC\*/NP/PA



## Informed Consent to Continue Medication(s)

Participant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby authorize, consent and direct the staff of ANASAZI Foundation, Inc. (hereinafter, ANASAZI) to continue to administer medications that have been prescribed for me/my child. I further acknowledge and certify that risks, if any, associated with using such medications in a wilderness environment may be significant and have been thoroughly explained, and accepted by, me.

I have informed the prescribing physician of my intent to admit myself/my child into ANASAZI and of the nature of the program.

I accept the risk associated with this decision and hold ANASAZI harmless from any negative effects of such administration of medication.

\_\_\_\_\_  
Participant (if 18 years or older)                      Date

\_\_\_\_\_  
Mother/Legal Guardian                      Date                      Father/Legal Guardian                      Date



## Important Medication Notice – Medications Supplied On Trail

If you need medication while on the trail, **you are responsible** to ensure the ordering practitioner contacts *The Apothecary Shop*, ANASAZI's preferred pharmacy, to fill your prescription(s). The physician should order enough medication for **eight (8) full weeks**. This will ensure you have enough medication while at ANASAZI, including any possible extension. All leftover medication will be provided to you on your discharge date.

Because your safety comes first, there are some medications **not** usually permitted on the trail. These medications are as follows:

- Antipsychotics
- Atypical antipsychotics
- Mood stabilizers
- Anti-anxiety agents
- Anti-panic agents
- Sleeping pills
- Seizure medications
- Acne medications
- Medications that may cause:
  - drowsiness
  - lack of coordination
  - dehydration
  - sun sensitivity
- Medications that require monitoring of blood work

**These are general guidelines and all cases may be considered on an individual basis, as necessary.** If you have questions about the use of your medication on the trail, please speak with the admissions director or the nursing staff. Other medications discouraged are vitamins, herbal products, and any other medication that may be eliminated without causing adverse effects.

No medications will be permitted on the trail unless they are provided through The Apothecary Shop. This also includes any over-the-counter medications. For safety reasons, the pharmacy will separate medications into packages for each of the eight weeks. The pharmacy fee for processing prescriptions is \$25 per person. If you need a prescription while on the trail that was not prescribed before the day of admission, you will be charged an additional packaging fee of \$25 per prescription, plus the cost of the medication. This fee will include delivery. Full payment must be made before the pharmacy will deliver your medication. We encourage you to take care of this immediately to ensure your medications are ready on the day of admission.

Your insurance information can be submitted to the pharmacy. Most insurance covers a maximum of 30 days. If insurance does not cover the full eight weeks, you will be billed for the remainder, which you may then submit for insurance reimbursement.

**The Apothecary Shop**  
**2450 E. Guadalupe Rd.**  
**Gilbert, AZ 85234**  
**Phone: 480-633-6934**  
**Fax: 480-633-6974**

\_\_\_\_\_  
Participant (if 18 years or older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mother/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Father/Legal Guardian

\_\_\_\_\_  
Date



## Personal Health and Medical History

Please explain "YES" answers in detail, **circle** questions you do not know the answers to, and provide all other information that might be important to your safe participation in the program. If you answer "YES" to any of the items below, a consent to participate form, signed by your treating physician, may be required prior to admission.

PARTICIPANT'S NAME \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_ GENDER: M / F  
 PRIMARY CARE PRACTITIONER \_\_\_\_\_ PHONE: \_\_\_\_\_

- |   | Yes                      | No                       |  | Yes                      | No                       |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Do you have any allergies to any medications?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 2. Have you ever had an allergic reaction (for example, to food, pollen, medicine, or stinging insects)?                      | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Have you ever had a rash or hives develop during or after exercise?   |                          |                          |  |                          |                          |
| 3. Have you ever been hospitalized overnight?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Have you ever had a surgery?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 4. Are you currently taking any prescription or Non-prescription (over-the-counter) medications or pills or using an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?                  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 5. Have you ever passed out during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Have you ever been dizzy during or after exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Have you ever had chest pain during or after exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Do you get tired more quickly than your friends do during exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Have you ever had racing of your heart or skipped heartbeats?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Have you had high blood pressure or high cholesterol?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Have you ever been told you have a heart murmur?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Has any family member or a relative died of heart problems or of sudden death before age 50?                                  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?                      | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Has a physician ever denied or restricted your participation in sports for any heart problems?                                | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?                    | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 7. Have you ever had a head injury or concussion?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Have you ever been knocked out, become unconscious, or lost your memory?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Have you ever had a seizure?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Do you have frequent or severe headaches?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Have you ever had numbness or tingling in your arms, hand, legs, or feet?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Have you ever had a stinging, burning, or pinched nerve?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 8. Have you ever become ill from exercising in the heat?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 9. Do you cough, wheeze, or have trouble breathing during or after activity?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Do you have asthma?   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Do you have seasonal allergies that require medical treatment?  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
|   |                          |                          | 10. Do you use any special protective or corrective equipment or devices that aren't regularly used for athletic activity (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 11. Have you had any problems with your eyes or vision?  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Do you wear glasses, contacts, or protective eyewear?  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 12. Have you ever had a sprain, strain, or swelling after injury?  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Have you broken or fractured any bones or dislocated any joints?   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | <i>If yes, check appropriate box and explain below.</i>  |                          |                          |
|   |                          |                          | <input type="checkbox"/> Head <input type="checkbox"/> Elbow <input type="checkbox"/> Hip  |                          |                          |
|   |                          |                          | <input type="checkbox"/> Neck <input type="checkbox"/> Forearm <input type="checkbox"/> Thigh  |                          |                          |
|   |                          |                          | <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Knee   |                          |                          |
|   |                          |                          | <input type="checkbox"/> Chest <input type="checkbox"/> Hand <input type="checkbox"/> Shin/Calf  |                          |                          |
|   |                          |                          | <input type="checkbox"/> Shoulder <input type="checkbox"/> Finger <input type="checkbox"/> Ankle   |                          |                          |
|   |                          |                          | <input type="checkbox"/> Upper arm <input type="checkbox"/> Foot   |                          |                          |
|   |                          |                          | 13. Do you want to weigh more or less than you do now?   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Do you lose weight regularly to meet weight requirements for your sport?   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 14. Do you feel stressed out?  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | <b>15. Please attach your most recent immunization record.</b>   |                          |                          |
|   |                          |                          | Record the dates of your most recent immunizations (shots) for:  |                          |                          |
|   |                          |                          | Tetanus _____ Measles _____  |                          |                          |
|   |                          |                          | Hepatitis B _____ Chickenpox _____   |                          |                          |
|   |                          |                          | <b>Females Only</b>  |                          |                          |
|   |                          |                          | 16. When was your first menstrual period? _____  |                          |                          |
|   |                          |                          | When was your most recent menstrual period? _____  |                          |                          |
|   |                          |                          | How much time do you usually have from start of one period to the start of another? _____  |                          |                          |
|   |                          |                          | How many periods have you had in the last year? _____  |                          |                          |
|   |                          |                          | What was the longest time between periods in the last year? _____  |                          |                          |
|   |                          |                          | <b>Explain "Yes" answers here</b>  |                          |                          |
|   |                          |                          | _____  |                          |                          |
|   |                          |                          | _____  |                          |                          |
|   |                          |                          | _____  |                          |                          |
|   |                          |                          | _____  |                          |                          |



**NOTE: This form captures PARENT/SPOUSE health information (for the trail experience).**

## Parent/Spouse Personal Health and Medical History (1)

At the end of the ANASAZI experience, your parents and/or spouse will have the opportunity to spend 3 days and 2 nights with you in the wilderness. In order to ensure their safe and full participation, please ask them to provide the following information.

Client Name: \_\_\_\_\_

Parent/Spouse Name: \_\_\_\_\_

Age: \_\_\_\_\_

Gender: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

### MEDICAL INFORMATION

Do you currently experience or have a history of any of the following?

Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Back Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____		
Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____		

### ALLERGIES

Please indicate any allergies to food, medication, plants or insects (including bees):

Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergy: \_\_\_\_\_ Reaction: \_\_\_\_\_

### MEDICATION

Describe prescription and over-the-counter medications currently being taken. (Use additional sheet if necessary).

Medication: \_\_\_\_\_ Reason: \_\_\_\_\_

Medication: \_\_\_\_\_ Reason: \_\_\_\_\_

Medication: \_\_\_\_\_ Reason: \_\_\_\_\_

Medication: \_\_\_\_\_ Reason: \_\_\_\_\_

### RECOMMENDATIONS

- Current Tetanus Toxoid immunization
- Several weeks prior to your ANASAZI experience, we suggest physical preparation such as hiking and walking.
- Many people in the outdoors get dehydrated. Dehydration can be prevented by consuming enough water to replace fluids lost (through perspiration, respiration and urination) and by eating salty foods. Begin drinking prior to the trail experience.
- If you have any questions or concerns please contact our nurse at (480) 892-7403.

Parent/Spouse Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**NOTE: This form captures PARENT/SPOUSE health information (for the trail experience).**

## Parent/Spouse Personal Health and Medical History (2)

At the end of the ANASAZI experience, your parents and/or spouse will have the opportunity to spend 3 days and 2 nights with you in the wilderness. In order to ensure their safe and full participation, please ask them to provide the following information.

Client Name: \_\_\_\_\_

Parent/Spouse Name: \_\_\_\_\_

Age: \_\_\_\_\_

Gender: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

### MEDICAL INFORMATION

Do you currently experience or have a history of any of the following?

Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Back Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Other:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____		
Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____		

### ALLERGIES

Please indicate any allergies to food, medication, plants or insects (including bees):

Allergy: _____	Reaction: _____
Allergy: _____	Reaction: _____
Allergy: _____	Reaction: _____
Allergy: _____	Reaction: _____

### MEDICATION

Describe prescription and over-the-counter medications currently being taken. (Use additional sheet if necessary).

Medication: _____	Reason: _____
Medication: _____	Reason: _____
Medication: _____	Reason: _____
Medication: _____	Reason: _____

### RECOMMENDATIONS

- Current Tetanus Toxoid immunization
- Several weeks prior to your ANASAZI experience, we suggest physical preparation such as hiking and walking.
- Many people in the outdoors get dehydrated. Dehydration can be prevented by consuming enough water to replace fluids lost (through perspiration, respiration and urination) and by eating salty foods. Begin drinking prior to the trail experience.
- If you have any questions or concerns please contact our nurse at (480) 892-7403.

Parent/Spouse Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Gear & Outfitting

With the exception of the following, ANASAZI will provide all gear necessary to outfit you for 42 days. If you extend beyond 42 days, additional fees may apply.

You must supply the following undergarments/supplies upon enrollment.

- 24 sets of underwear (no thong cut)
- Women: 8 non-cotton sports bras, qty. 96 feminine hygiene products

To assist ANASAZI with your gear needs, please provide the information below.

Participant's Common Name: \_\_\_\_\_

Gender:      MALE          FEMALE

Circle size AND write numbered sizes to the right of each article of clothing below:

Boots:          \_\_\_\_\_

Pants:          XS, S, M, L, XL or XXL          \_\_\_\_\_

Shirt:          XS, S, M, L, XL or XXL          \_\_\_\_\_

Underwear:   XS, S, M, L, XL or XXL          \_\_\_\_\_

Bra:            XS, S, M, L, XL or XXL          \_\_\_\_\_

**Please have your parents/spouse take home all non-trail belongings...luggage, street clothes, cell phones, iPods, jewelry, wallets, etc. ANASAZI cannot guarantee the security of items left behind.**

## Hotels in the Mesa Area

Rates may vary according to month and availability.  
Reservations should be made in advance.  
All hotels listed are within a few miles of ANASAZI

**\*Marriott Courtyard\*\***

1221 S. Westwood  
Toll-Free: 800-835-6205  
Local: 480-461-3000

**Best Western**

250 W. Main  
Toll-Free: 800-528-1234  
Local: 480-834-9233

**\*Country Inn and Suites**

6650 Superstition Springs  
Toll-Free: 800-456-4000  
Local: 480-641-8000

**\*Days Inn**

333 W. Juanita  
Toll-Free: 800-325-2525  
Local: 480-844-8900

**\*Hampton Inn**

1563 S Gilbert Rd.  
Toll-Free: 800-426-7866  
Local: 480-926-3600

**Hilton**

1011 W. Holmes  
Toll-Free: 800-445-8667  
Local: 480-833-5555

**\*Holiday Inn**

1600 S. Country Club  
Toll-Free: 800-465-4329  
Local: 480-964-7000

**Motel 6**

1511 S. Country Club  
Toll-Free: 800-466-8356  
Local: 480-834-0066

**Phoenix Marriott Mesa**

200 N. Centennial Way  
Local: 480-898-8300

**Super 8**

1550 S. Gilbert Rd.  
Toll-Free: 800-800-8000  
Local: 545-0888

**\*Ask for special ANASAZI rates**

**\*\*Shuttle service available**

*For airport shuttle service, contact Super Shuttle at 602-244-9000*

## Map and Directions to ANASAZI Office



**ANASAZI Foundation**  
1424 South Stapley Drive  
Mesa, Arizona 85204

Head east from Sky Harbor Airport towards 44<sup>th</sup> Street/East Valley cities. Merge onto the Loop 202 freeway. Take 202 East to the Loop 101 freeway. Take 101 South to US 60 east (exit 55A). Take US 60 East (towards Mesa and Globe) to Stapley Drive (exit 181). Head North (left) on Stapley Drive to Harmony (the first light past the overpass). Turn left at light on Harmony. Our offices are on the Northwest corner. Take the first driveway right into the ANASAZI parking lot. Enter ANASAZI offices from the parking lot door.