

CHURCH OF SACRED SACRAMENTS

A First Amendment Free Church | IRC 508(c)(1)(A) | Montana Location | Nationwide Ministry

MEDICAL SCREENING & CONTRAINDICATIONS ASSESSMENT

Required Before Every Ceremony Participation

CONFIDENTIAL RELIGIOUS RECORD — PASTORAL PRIVILEGE PROTECTED

This medical screening is a sacred ecclesiastical record protected under pastoral privilege. It is collected solely to ensure the safety and wellbeing of participants in religious ceremony. It shall not be disclosed to any third party except as required in a genuine medical emergency.

CRITICAL INSTRUCTIONS — READ BEFORE COMPLETING

1. Answer ALL questions honestly and completely. Your safety depends entirely on accurate information.
2. Do NOT omit information you think might disqualify you. Facilitators can work with you to determine appropriate safety measures.
3. This is a confidential religious record protected under pastoral privilege. It will not be shared without your consent except in a genuine medical emergency.
4. Consult your physician if you have questions about your medications or medical conditions before completing this form.

I. PARTICIPANT INFORMATION

Full Legal Name: _____

Date of Birth: _____ Age: _____ Weight: _____

Date of Screening: _____ Screening Completed By: _____

II. CURRENT MEDICATIONS

List ALL medications you are currently taking, including prescription, over-the-counter, supplements, vitamins, and herbal remedies. Do not omit anything.

Medication Name	Dosage	Frequency	Purpose	How Long Taking?

CRITICAL: Are you currently taking ANY of the following? Check all that apply.
 These medications have SERIOUS or DANGEROUS interactions with entheogenic sacraments. Full disclosure is required.

- **SSRIs (Prozac, Zoloft, Lexapro, Paxil, Celexa, etc.) — MAJOR INTERACTION RISK**
- **MAOIs (Nardil, Parnate, Marplan, etc.) — DANGEROUS WITH DMT/AYAHUASCA — POTENTIAL FATALITY**
- **Lithium — CONTRAINDICATED**
- Tramadol or other opioids — INTERACTION RISK
- Blood pressure medications (any class)
- Heart medications / antiarrhythmics
- **Antipsychotics (Risperdal, Seroquel, Abilify, etc.)**
- Benzodiazepines (Xanax, Klonopin, Ativan, Valium, etc.)
- Immunosuppressants
- None of the above

If taking SSRIs or MAOIs — Date of last dose: _____

III. MENTAL HEALTH HISTORY

Have you ever been diagnosed with or experienced any of the following? Please provide details — your safety depends on honest, complete answers.

Condition / History	Yes	No	Details / Notes
Schizophrenia or psychotic disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>Details:</i>
Bipolar disorder (Type I or II)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>Details:</i>
Severe depression or major depressive disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>Details:</i>
Suicidal thoughts or past attempts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>Details:</i>
Severe anxiety or panic disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>Details:</i>
PTSD or complex trauma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>Details:</i>

Dissociative disorder or DID	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>Details:</i>
Personality disorder (BPD, NPD, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>Details:</i>
Eating disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>Details:</i>
Obsessive-compulsive disorder (OCD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>Details:</i>
ADHD or ADD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<i>Details:</i>

Family Mental Health History

- Schizophrenia or psychotic disorder in immediate family
- Bipolar disorder in immediate family
- Severe mental illness in family (specify below)
- No significant family mental health history

Specify if applicable: _____

Current Mental Health Status

My current mental health status is best described as:

- Stable and well-managed
- Generally stable with some ongoing challenges
- Currently struggling but not in crisis
- In crisis or acute distress — CONTACT FACILITATOR BEFORE PROCEEDING

Currently seeing a therapist or psychiatrist? Yes No

If yes — Provider Name & Contact: _____

Hospitalized for mental health in the past 5 years? Yes No

If yes — When and why: _____

IV. PHYSICAL HEALTH HISTORY

Condition / History	Yes	No	Details / Notes
Heart disease or heart attack history	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Details:
High blood pressure (hypertension)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Details:
Arrhythmia or irregular heartbeat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Details:
Stroke or TIA (mini-stroke)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Details:
Seizure disorder or epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Details:
Diabetes (Type 1 or 2)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Details:
Liver disease or hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Details:
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Details:
Thyroid disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Details:
Autoimmune disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Details:
Cancer (current or history)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Details:
Chronic pain condition requiring medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Details:

Currently pregnant, possibly pregnant, or breastfeeding? Yes — ABSOLUTE CONTRAINDICATION No Not applicable

V. SUBSTANCE USE HISTORY

Current Alcohol Use

- None
- Occasional (1–2 drinks per week)
- Moderate (3–7 drinks per week)
- Heavy (8+ drinks per week or binge drinking) — Discuss with facilitator

History of alcohol abuse or dependence? Yes, currently in recovery (sober for: _____)
 Yes, resolved No

Other Substance Use (Current or Past)

Substance	Current Use?	Past Use?	Abuse / Dependence History?
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cocaine / Stimulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opioids (non-prescribed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benzodiazepines (non-prescribed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MDMA / Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ketamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If history of substance abuse — currently in recovery or treatment? Yes No N/A

If yes — Type of treatment / support: _____

VI. PRIOR ENTHEOGENIC EXPERIENCE

Please be honest about prior experience. Prior use does not disqualify you — it helps facilitators understand your relationship with these medicines.

Substance	Prior Use?	Approx. # of Times	Most Recent Use
Psilocybin Mushrooms	<input type="checkbox"/> Yes <input type="checkbox"/> No		
DMT / Ayahuasca / Yopo	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Peyote / Mescaline	<input type="checkbox"/> Yes <input type="checkbox"/> No		
LSD / Lysergamides	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other psychedelics (specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Have you ever had a difficult or overwhelming psychedelic experience? Yes No

If yes — Describe briefly: _____

Have you ever experienced psychedelic-induced psychosis, lasting panic, or HPPD? Yes No

CRITICAL — If yes, describe in detail: _____

: _____

VII. CURRENT LIFE CIRCUMSTANCES

Check all current stressors that apply:

- Major life transition (move, career change, etc.)
- Job loss or unemployment
- Serious illness (self or family member)

- | | |
|---|--|
| <input type="checkbox"/> Relationship crisis or divorce | <input type="checkbox"/> Custody or family conflict |
| <input type="checkbox"/> Financial hardship or housing insecurity | <input type="checkbox"/> Active trauma or crisis situation |
| <input type="checkbox"/> Legal issues or pending court matters | <input type="checkbox"/> None — life is relatively stable |
| <input type="checkbox"/> Recent death of a loved one | |

Current stress level (1–10): _____

VIII. SPIRITUAL & EMOTIONAL READINESS

Primary intention for this ceremony:

Emotional readiness for a potentially challenging experience:

- Yes — I am ready to face whatever arises
- Mostly ready, with some nervousness (normal)
- Unsure — discuss with facilitator before proceeding
- No — I am anxious or fearful — MUST speak with facilitator before proceeding

Integration support available afterward:

- Strong support system available
- Some support available
- Limited support — Church integration resources recommended
- No personal support — Church integration resources required before approval

IX. EMERGENCY CONTACT

Emergency Contact Full Name: _____

Relationship:

Phone Number:

Does this person know you are participating in a sacramental ceremony? Yes No
(will only contact in true emergency)

X. ABSOLUTE CONTRAINDICATIONS — FACILITATOR REVIEW REQUIRED

AUTO-DISQUALIFYING CONDITIONS

The following conditions represent absolute contraindications. Participation is NOT approved unless a full ministerial override is granted after consultation with qualified medical and spiritual advisors.

1. Active psychotic symptoms or current schizophrenia diagnosis
2. Current suicidal ideation with plan or intent
3. Uncontrolled bipolar disorder (currently manic or in severe depressive episode)
4. Current MAOI use — must be fully discontinued for minimum 2 weeks
5. Current Lithium use — must be fully discontinued for minimum 2 weeks (under physician supervision)
6. Pregnancy or breastfeeding
7. Severe uncontrolled hypertension (blood pressure >180/110 systolic/diastolic)
8. Recent heart attack or stroke (within 6 months)
9. Active seizure disorder not controlled by medication
10. Active substance abuse or current intoxication at time of ceremony

XI. FACILITATOR ASSESSMENT

CONTRAINDICATION LEVEL — Facilitator Assessment:

<input type="checkbox"/> GREEN	No contraindications identified. Cleared for full participation.
<input type="checkbox"/> YELLOW	Minor concerns noted. May proceed with modifications (reduced dosage, additional support, modified setting).
<input type="checkbox"/> ORANGE	Moderate concerns identified. Requires full ministerial review before approval. Do not proceed without council sign-off.
<input type="checkbox"/> RED	Absolute contraindication present. Participation not approved at this time. Ministerial override required.

Facilitator Notes and Recommendations:

Ceremony Participation Decision:

- APPROVED — Full standard dosage
- APPROVED — Reduced dosage recommended (specify):

- APPROVED — Additional support measures required (specify):

- CONDITIONAL APPROVAL — Pending: _____
- NOT APPROVED — Reason: _____

Facilitator Signature

Facilitator Printed Name: _____

Date: _____

XII. PARTICIPANT CERTIFICATION

I certify under penalty of perjury that:

- All information I have provided on this form is true, complete, and accurate to the best of my knowledge.
- I have not withheld any information that might affect my safety or the safety of others.
- I understand that providing false information may result in immediate termination of membership.
- I accept full personal responsibility for my participation decision and for the accuracy of my disclosures.

Participant Signature

Participant Printed Name: _____

Date: _____

Document Version: 3.0 (Official Edition) | Church of Sacred Sacraments
CONFIDENTIAL RELIGIOUS RECORD — Retain in secure Church records. Do not disclose without participant consent.

This form must be reviewed by a licensed medical professional before implementation.