CAMP HEALTH HOPE HAPPINESS CAMPER MEDICAL FORM

THIS FORM **MUST NOT** BE COMPLETED EARLIER THAN JANUARY 1, 2017 AND **MUST** BE COMPLETED BY CAMPER'S PHYSICIAN

NAME OF THE CAMPER: _____BIRTHDATE: _____
Month/Day/Year

DISABILITY: _____

PERTINENT MEDICAL CONDITION(S) (DIABETES, EPILEPSY, HEART PROBLEMS, COMMUNICABLE DISEASES etc.):

_____

_____

1. Is the camper prone to any of the following? ☐ FAINTING ☐ ASTHMA OR RESPIRATORY PROBLEMS ☐ HEADACHES ☐ NAUSEA/VOMITING ☐ HEART PROBLEMS ☐ ATTENTION SEEKING BEHAVIOR (IE. FAKING ILLNESS) ☐ OTHER_____

2. Is the camper subject to SEIZURES? ☐ YES ☐ NO

FREQUENCY OF SEIZURES: _____

DURATION: _____

DESCRIPTION OF SEIZURES: _____

BEHAVIOR AFTER SEIZURES: _____

3. Is the camper subject to ALLERGIES? ☐ YES ☐ NO

ALLERGIES: _____

REACTION: _____

_____

RECOMMENDED TREATMENT FOR REACTION: _____

_____

4. Does the camper have DIABETES? ☐ YES ☐ NO

   I. IS THE CAMPER ON INSULIN? ☐ YES ☐ NO

   II. HOW OFTEN DO THEY NEED THEIR BLOOD SUGARS CHECKED? _____

5. Does the camper have any of the following: ☐ OSTOMY ☐ CATHETER ☐ GASTROSTOMY TUBE

6. Does the camper have BOWEL MOVEMENTS: ☐ INDEPENDENTLY ☐ WITH OUTSIDE ASSISTANCE

(SUPPOSITORY OR ENEMA)

I. DESCRIBE THE CAMPER'S BOWEL PATTERN: ☐ ONCE/DAY ☐ EVERY 2-3 DAYS ☐ ONCE/WEEK

7. Is the camper taking any MEDICATIONS (INCLUDING VITAMINS AND MINERALS)? ☐ YES ☐ NO

NAME	DOSAGE	TIME(S) GIVEN	ROUTE (PO/IM/SQ)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALL MEDICATIONS MUST COME PREPACKAGED IN DOSETTES OR BUBBLE PACKS, INCLUDING PRNS

PLEASE ATTACH A COPY OF THE CAMPER'S MED ADMIN RECORD (MAR) OR COMPLETE LIST OF MEDICATIONS

8. The following PRN MEDICATIONS can be given to the camper within the discretion of the camp nurse:

I. Acetaminophen (Tylenol) 325 mg, take 1-2 tablets every 4-6 hours as needed ☐ YES ☐ NO

II. Dimenhydrinate (Gravol) 50 mg, take 1-2 tablets every 6-8 hours as needed ☐ YES ☐ NO

III. Benadryl, take 2 tablets every 6 hours while symptoms persist ☐ YES ☐ NO

IV. Suppository or Laxative, administered as required to alleviate symptoms ☐ YES ☐ NO

10. Does the camper have a SPECIAL DIET? ☐ YES ☐ NO

I. If so, what kind? ☐ DICED ☐ MINCED ☐ PUREED ☐ DIABETIC ☐ MILK FREE ☐ LACTOSE FREE ☐ OTHER_____

11. Does the camper require THICKENED FLUIDS? ☐ YES ☐ NO

I. If so, what level? ☐ LEVEL 1 (NECTAR) ☐ LEVEL 2 (HONEY) ☐ LEVEL 3 (PUDDING)

12. Are there any RESTRICTIONS TO PHYSICAL ACTIVITY while the camper is at camp (ie. swimming, climbing wall etc.)? If so, describe _____

*****This section must be completed in full in order for the medical form to be considered valid*****

NAME OF PHYSICIAN (Please print clearly): _____

PHONE NUMBER: _____

DATE OF PHYSICIAN EXAM: _____

SIGNATURE OF PHYSICIAN: _____