

# CAMP HEALTH HOPE HAPPINESS CAMPER MEDICAL FORM

THIS FORM **MUST NOT** BE COMPLETED EARLIER THAN JANUARY 1, 2018 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.):

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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: \_\_\_\_\_

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