CAMP HEALTH HOPE HAPPINESS CAMPER MEDICAL FORM

THIS FORM **MUST NOT** BE COMPLETED EARLIER THAN JANUARY 1, 2020 AND **MUST** BE COMPLETED BY CAMPER'S PHYSICIAN

HEALTH CARE # _____

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 ☐ HEADACHES ☐ NAUSEA/VOMITING
   ☐ ASTHMA OR RESPIRATORY PROBLEMS ☐ 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

ALLERGEN (celiac, bee stings, latex etc.)	MIN EXPOSURE REQUIRED TO CAUSE REACTION (consumption, inhalation, touched, prolonged exposure, injected)	REACTION	RECOMMENDED TREATMENT

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 BOWEL MOVEMENT regularity need to be monitored while the camper is at Camp? ☐ YES ☐ NO

7. What is the camper's typical bowel pattern? ☐ ONCE/DAY ☐ EVERY 2-3 DAYS ☐ ONCE/WEEK

8. Does the camper require assistance for BOWEL MOVEMENTS?

☐ NO/ INDEPENDENT ☐ PROMPTING ☐ INCREASED FIBER ☐ ORAL LAXATIVE ☐ SUPPOSITORY OR ENEMA

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

PLEASE ATTACH A COPY OF THE CAMPER'S MED ADMIN RECORD (MAR) OR COMPLETE LIST OF MEDICATIONS ON THE PROVIDED "WEEKLY MEDICATION LOG

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

10. 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. Oral Laxative, administered as required to alleviate symptoms ☐ YES ☐ NO

V. Suppository/Enema, administered as required to alleviate symptoms ☐ YES ☐ NO

11. Does the camper require a SPECIAL DIET? ☐ YES ☐ NO

If so, what kind? ☐ DICED ☐ MINCED ☐ PUREED ☐ DIABETIC ☐ MILK FREE ☐ GLUTEN FREE

☐ OTHER_____

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

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

13. 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 MEDICAL FORM SIGNED: _____

Month/Day/Year

SIGNATURE OF PHYSICIAN: _____

Camper's Name:___________________________
Date Form Completed: ______________________
Page ________ of ________

Weekly Medication Log

Medication Name	Dosage	Delivery Method (crushed, w/ apple sauce, milk, food etc..)		Sun	Mon	Tue	Wed	Thurs	Fri	Sat	Notes
			AM								
			Noon								
			PM								
			Bed								
			PRN								
			AM								
			Noon								
			PM								
			Bed								
			PRN								
			AM								
			Noon								
			PM								
			Bed								
			PRN								
			AM								
			Noon								
			PM								
			Bed								
			PRN								
			AM								
			Noon								
			PM								
			Bed								
			PRN								

Please list all medications including prescriptions, vitamins, herbals, lotions, inhalers etc.
For all lotions, please include instructions for application including specific location.