MEDICAL FORM

Please attach a 2 inch by 2 inch recent photo here.

NAME OF CAMPER_____ BIRTHDATE_____

ADDRESS_____ HOME PHONE_____

CITY, STATE, ZIP_____ WORK PHONE_____

TO BE FILLED IN BY PARENT OR GUARDIAN: Has the camper had the following?

Rheumatic Fever_____ Mumps_____ Hay Fever_____

Chicken Pox_____ Pneumonia_____ Epilepsy_____

Measles_____ Diabetes_____

Allergies (to what – type reaction)_____

Does your son or daughter have any reaction to:

Sulfa Drugs_____ Penicillin_____ Other Drugs_____

Immunizations (please give dates):

Diphtheria/Tetanus_____ Polio Vaccine_____

Measles/Mumps/Rubella_____

Hepatitis A_____ Hepatitis B_____

Has your son or daughter received medical treatment for any major illnesses during the past year? If so, please give dates, reason and doctor. Please have the other side of this form completed.

_____

_____

_____

What medicine, if any, will the camper bring to camp?_____

What special diet, if any, will camper need?_____

Comments concerning activity restrictions, bed-wetting, medication, menstrual history, etc.:_____

_____

_____

PLEASE NOTE:

If camper has medical insurance under Medicaid or Medicare, a copy of their eligibility certificate needs to be attached to this medical form.

FAMILY INSURANCE COVERAGE:_____

_____

CONSENT FOR TREATMENT: This is to certify that we, the under-signed Parent or Guardian, consent to whatever Medical or Surgical treatment may be deemed necessary or advisable by the attending physician while my child is at CampCare or in transit to and from camp.

Signed_____

Parent/Guardian

PLEASE NOTIFY IN CASE OF EMERGENCY:

NAME(S)_____

PHONE(S)_____

SUMMER CAMP MEDICAL FORM (Supplement)

TO BE FILLED IN BY FAMILY DOCTOR:

TO BE COMPLETED FOR ALL CHILDREN WITH SPECIAL HEALTHCARE NEEDS i.e.: SEIZURES, DEVELOPMENTAL DISABILITIES, CEREBRAL PALSY, ASTHMA, DIABETES, ALLERGIES, ETC.

NAME_____ BIRTHDATE_____

ADDRESS_____ HOME PHONE_____

_____ WORK PHONE_____

MEDICAL HISTORY AGE_____ SEX_____

DIAGNOSIS (1)_____ Year diagnosis made_____

(2)_____ Year diagnosis made_____

SUMMARY OF SIGNIFICANT SYMPTOMS, DISABILITIES OR NEEDS AT PRESENT

(Describe type, frequency, and duration of any seizures, attacks or unusual reactions)

(1)_____

(2)_____

SUMMARY OF SIGNIFICANT PHYSICAL FINDINGS AT PRESENT:

(1)_____

(2)_____

SUMMARY OF SIGNIFICANT RECENT LABORATORY DATA:

(1)_____

(2)_____

SUMMARY OF PRESENT MEDICATION (NAME, DOSE, FREQUENCY):

(1)_____

(2)_____

SUMMARY OF PRESENT ACTIVITY LEVEL AND LIMITATIONS:

(1)_____

(2)_____

ADDITIONAL NOTES:

I have examined the camper named above and find him/her qualified to attend CampCare and to share in all normal camp activities with the following exceptions:_____

_____

Date:_____ Signed:_____

Signature

PRINT NAME:_____

Phone Number:_____