CampCare Medical Form

DATE:_____ ATTACH PHOTO HERE:

TO BE FILLED OUT BY PARENT/GUARDIAN

NAME OF CAMPER: _____DATE OF BIRTH:

ADDRESS: _____ HOME PHONE:

CITY, STATE, ZIP: _____CELL PHONE:

PLEASE NOTIFY IN CASE OF EMERGENCY:

ESPECIALLY IF YOU ARE GOING TO BE UNAVAILABLE DURING CAMP:

NAMES (S) _____

PHONE NUMBERS:

DOES YOUR SON/DAUGHTER HAVE ANY REACTION TO THE FOLLOWING? IF SO, PLEASE INDICATE WHAT TYPE OF REACTION: Anaphylactic Reaction _____

SULFA DRUGS _____ PENICILLIN _____BEE STINGS_____

OTHER DRUGS _____ALLERGIES/HAY FEVER_____

IMMUNIZATIONS: UP TO DATE:

DIPHTHERIA/TETANUS YES_____ NO _____

Tdap BOOSTER DATE BOOSTER GIVEN _____

MEASLES/MUMPS/RUBELLA YES _____ NO _____

POLIO YES_____ NO _____

HEPATITIS A YES _____ NO _____

HEPATITIS B YES _____ NO _____

COVID-MUST GIVE DATES: 1ST DOSE_____2ND DOSE _____ BOOSTER_____

HAS YOUR SON/DAUGHTER RECEIVED MEDICAL TREATMENT FOR ANY MAJOR ILLNESS DURING THE PAST YEAR? IF SO, PLEASE GIVE DATES, REASON AND DOCTOR. PLEASE USE OTHER SIDE IF NEEDED:

_____

What medication, if any will camper bring to camp?

_____

What special diet if any, will camper need?

_____

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

_____

Insurance Coverage: _____ If camper has family insurance coverage, Medicare or Medicaid, please attach a copy to this form.

CampCare Medical Form

TO BE FILLED IN BY MEDICAL CARE PROVIDER:

TO BE COMPLETED FOR ALL CAMPERS REGARDING ANY HEALTHCARE NEEDS (IE: 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_____

DIAGNOSIS (2) _____YEAR DIAGNOSIS MADE_____

DIAGNOSIS (3) _____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) _____

(3) _____

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.

_____CAMPER IS QUALIFIED TO ATTEND WITH THE FOLLOWING EXCEPTIONS:

PHYSCIAN NAME: _____PHONE #_____

PHYSICAN SIGNATURE: _____DATE_____