CampCare Medical Form

TO BE FILLED OUT 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: _____ DATE OF BIRTH: _____
ADDRESS: _____ HOME PHONE: _____
CITY, STATE, ZIP: _____ WORK PHONE: _____
MEDICAL HISTORY:
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: _____
3: _____
SUMMARY OF PRESENT ACTIVITY LEVEL AND LIMITATIONS:
1: _____
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:

_____

_____

PRINT PHYSICIAN NAME: _____ PHONE #: _____

SIGNATURE: _____ DATE: _____