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:

PHYSICIAN NAME:_____ PHONE #_____

PHYSICIAN SIGNATURE:_____ DATE_____