Easter Seals Colorado Program Medical Form

Client Name: _____ Date of Birth: _____

Client Allergies (**If none, please write none**)_____

Client dietary needs: _____

Describe Client's general health status: GOOD FAIR POOR Client's current weight: _____

Please return this form *filled out and signed* by your physician no less than two weeks before session start date

Client participation will be suspended without completion of this form (4 PAGES)

Medical History:

1. Please attach a copy of the client's immunizations or immunization exemption forms
    a. *I verify that this client's immunizations are up-to-date and complete*

    PYSICIAN'S INITIALS _____

2. Date of last tetanus shot: _____ **(Mandatory Information)**

3. Has this client recently been exposed to a contagious disease? YES NO

    a. If yes, Please explain:

4. List any chronic health problems (e.g. asthma, pressure sores, wounds that will not heal, cough, constipation, etc.)

5. Has this client been exposed to Hepatitis B or considered a carrier of Hepatitis B? YES NO
    a. If yes, was a lab test conducted to determine the presence of antibodies? YES NO
    b. If yes, were antibodies present? YES NO

    PHYSICIAN'S INITIALS _____
6. Is the client a carrier of any other infectious or contagious condition? YES NO
    a. If yes, please explain:

7. Does this client have seizures? YES NO
    a. Type of seizure: _____

    b. How frequently do seizures occur: _____

c. How long do seizures last: _____

d. List rescue medications and at what point they are to be used: _____
_____
_____

Client's typical Pulse OX range: _____

Does this client require oxygen to maintain adequate O2 saturation? YES NO

Client's typical Blood Pressure: _____

Client's typical Heart Rate: _____

Restrictions:

1. Has the client been hospitalized or treated in an emergency room in the last 2 months? YES NO
   a. If yes, please explain:

2. Does this client have any existing conditions which should be considered in restriction of camp activity (e.g. spinal rods, ventilator, shunts, no submersion of head, etc.)? YES NO
   a. If yes, please explain:

3. ***Rocky Mountain Village Summer and Respite Camp Only****:* Does the client require a night attendant at home? YES NO
   a. If yes, the applicant must bring a night attendant with him/ her to camp. Prior arrangements must be made ahead of time with RMV for the client's night attendant.
   Please call (303) 569- 2333 to speak with Assistant Camp Director or Camp Nurse

4. Please indicate any specific emergency procedures to be followed for this client (e.g. in case of removal of g-tube, seizure lasting longer than 5 minutes, etc.):
   _____
   _____
   _____
   _____

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Medications: Please list **ALL** medications, vitamins, supplements, and treatment procedures (i.e. bowel programs) currently in use by this client.

Easter Seals Colorado will not administer ANY medications not indicated by physician's orders. IF A MEDICATION OR DOSAGE CHECNGE OCCURS AFTER THIS FORM HAS BEEN SUBMITTED TO CAMP, RMV must be provided with an updated order to pass those medications (please fax or email any medication updates to camp as they occur. The prescription on the medication bottle must match the physician's orders.

	Medication Name	Dosage	Frequency/ Times Given	Rout Given
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

Please describe how this client best takes medication (i.e. with pudding, place powders in milk vs. juice, takes all pills at once vs. one at a time, etc.): _____

A new medical form will be requested for each calendar year this individual participates at RMV

PHYSICIAN'S CONSENT AND SIGNATURE

Upon physician's exam, this client was free from any contagious or infectious disease or conditions posing risk to the health and safety of others beyond standard precautions. I verify that the above listed medications are current to this client and consent to their use as orders for this client I consent that this client is capable of participating in the programming of Easter Seals Colorado adult services and/ or Easter Seals Rocky Mountain Village Summer and Respite Camp. I agree to consult on and communicate with the Rocky Mountain Village medical staff regarding the health and medical status of this client while they are participating in Easter Seals Colorado programming.

Physician's Name (Please Print): _____

Physician's Office Phone: _____ Emergency Phone: _____

Address:

_____

Physician's Signature: _____ Date: _____