Easterseals Colorado Program Physical Form

Rocky Mountain Village

Client Name: _____ Date of Birth: _____

Diagnosis: _____ Client's Current Weight: _____

***Please return this form, *filled out and signed by your physician or prescribing authority*, 2 weeks prior to the start of your session. Client acceptance will be complete upon signature of these forms (2 pages).**

Medical History:

1. Date of last physician examination: _____ (Must be within 12 months prior to your session start date)

2. Has this client carried or been exposed to a contagious disease? YES NO
   a. If yes, please explain (Examples: Hepatitis, Tuberculosis, etc.) _____

3. Has this client traveled out of the country in the 9 months prior to camp start date? YES NO

4. List any chronic health problems (Examples: diabetes, wounds that will not heal, cardiac disease, etc.)
   _____

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: _____

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

   c. Please indicate any specific treatment or emergency procedures to be followed for this client (Examples: accidental removal of g-tube, ventilator care, bowel program, etc.)

Client Name: _____ Session: _____ Date: _____

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The CampBrain Medical Form must also be downloaded, printed, and then signed by a prescribing authority.

Medications: Please list ***All prescribed medications, vitamins, supplements & over the counter medications*** currently used by this client. Easterseals Colorado cannot administer any medications not indicated by prescribing authority's orders. IF A MEDICATION OR DOSAGE CHANGE OCCURS AFTER THIS FORM HAS BEEN SUBMITTED TO CAMP, RMV MUST BE PROVIDED WITH AN UPDATED ORDER TO PASS THOSE MEDICATIONS. Please email any medication updates to camp as they occur. The prescription on the medication bottle must match this prescriptive authority's orders. Check-in will run more efficiently if medications are brought in medication minders, with original containers containing one pill for verification. If they medication confirmation list does not match the medications brought to check-in, then you will either need to take that medication home or the camper may not be able to stay at RMV.

A new Medical Form will be requested for each calendar year this individual participates at RMV

PHYSICIAN OR PRESCRIBING AUTHORITY'S CONSENT AND SIGNATURE

Upon physical 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.

Physician or Prescribing Authority's Name (Please Print): _____

Physician or Prescribing Authority's Office Phone: _____

Physician or prescribing Authority's Signature: _____

Date: _____

Client Name: _____ Session: _____ Date: _____