Easterseals Camp Challenge
CAMPER MEDICAL FORM

(To be completed by a Licensed Medical Provider – 2 pages)

For Summer Camp 2026 this form must be signed by a licensed provider AFTER January 1, 2026

****UNLESS****

The camper is attending a weekend camp or Winter Camp AND did NOT attend in Summer 2025.

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY AND SIGNED & DATED TO BE VALID

Camper's Full Name:_____

Address: _____

DOB: / / **Age: _____** **Sex:_____** **Weight:_____**

Applicant's primary disability (Medical Diagnosis): _____

Secondary disability (if any): _____

Applicant is under the care of a physician for the following condition(s):_____

_____

IMMUNIZATION HISTORY

Does the camper have all the recommended vaccines? Yes [ ] No [ ] **Date of last Tetanus: _____**

If no, explain_____

ALL eligible campers are ENCOURAGED to receive the COVID-19 vaccine*

ALLERGIES (Food, Medication, Plants, Insects) _____

Reaction Type

☐ Anaphylaxis ☐ Rash/Hives ☐ Upset Stomach ☐ Other: _____

DIETARY RESTRICTIONS Yes [ ] No [ ]

If yes, explain:

_____

_____

FEEDING TUBE/G-TUBE Yes [ ] No [ ]

NOTES AND ADDITIONAL COMMENTS (please include any other information, including restrictions and limitations that we should be aware of):

_____

_____

SEIZURES: Yes [ ] No [ ] Type _____ Date of last seizure: _____

Known Seizure Triggers: _____ Medication Controlled? Yes [ ] No [ ]

NOTES AND ADDITIONAL COMMENTS (please include any other information, including restrictions and limitations that we should be aware of):

_____

_____

BOWEL HABITS: Frequency? _____ Preventive medications (e.g.: Miralax) _____

NOTES AND ADDITIONAL COMMENTS (please include any other information, including restrictions and limitations that we should be aware of):

_____

_____

MEDICATION: All medications, both prescription and OTC must be listed on the next page.

NO medications (prescription or over-the-counter), supplements, or vitamins will be given without a doctor's order.

Medication changes within the last 30 days? Yes [ ] No [ ] If yes, explain_____

_____

CURRENT PRESCRIPTION MEDICATIONS TO BE TAKEN AT CAMP: (Attach pages as necessary)

NAME	DOSAGE	TIME GIVEN	REASON FOR TAKING

CURRENT OVER THE COUNTER MEDICATIONS TO BE TAKEN AT CAMP: (Vitamins, OTC Allergy Medication, etc.)

NAME	DOSAGE	TIME GIVEN	REASON FOR TAKING

Camp Challenge medical staff routinely administer the following over-the counter medications. Please check all medications that may be given to the camper on an as-needed basis.

☐ **Camper may have ALL of the medications listed below**

☐ Acetaminophen 325mg ☐ Ibuprofen ☐ Barrier Cream (Zinc Oxide) ☐ Eye Drops (Visine)
☐ Diphenhydramine HCL ☐ Glycerin Suppository ☐ Antacid (Tums) ☐ Pepto Bismal
☐ Hydrocortisone Cream ☐ Triple Antibiotic Cream ☐ Aloe ☐ Nasal Decongestant
☐ Cold and Allergy Medicine ☐ Unisom (Sleep Aid) ☐ Bacitracin Ointment

PHYSICIANS STATEMENT THIS SECTION MUST BE FILLED OUT IN ITS ENTIRETY

Can the camper safely be in a 1:3 staff to camper ratio? ☐ Yes ☐ No
Can the camper be outside for approximately 1 hour at a time? ☐ Yes ☐ No
Can the camper safely sleep overnight in a cabin environment? ☐ Yes ☐ No
Is the camper at excessive risk for dehydration? ☐ Yes ☐ No

I have examined the camp applicant. In my opinion, the camper's disability, health condition, and/or behavior:

Allows [ ] Does Not Allow [ ] his/her participation in an active camp program within the 1:3 staff to camper ratio.

The camper is specifically able to participate in the following activities:

[ ] Swimming (Shallow-Water Pool)

[ ] Outdoor Activities lasting 45-60 minutes

This medical form is used for year-round camping programs and valid for one year. Is the camper's health likely to remain stable during that time?* [ ] yes [ ] no

May a camp representative contact the office with any questions/need for clarification? [ ] yes [ ] no

_____

Caregiver Signature

*An updated form may be requested prior to extended camping programs

_____ _____

Licensed Physician's Signature Physician Name (printed)

_____ _____

Date of Most Recent Examination Today's Date

Physician Address:_____

City_____ State _____ Zip Code _____

Phone: ( ) _____

Camper's Full Name:_____

Medical Form Revised 09.2025