



# Easterseals Camp Challenge CAMPER MEDICAL FORM



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

**For Summer Camp this form must be signed by a licensed provider between April 1 and June 1, 2023. For campers who did not attend camp Summer 2022 and are attending Weekend or Weeklong Camp this form must be completed prior to the first session the camper attends.**

**THIS FORM MUST BE COMPLETED IN ITS ENTIRETY AND SIGNED & DATED ON BOTH PAGES TO BE VALID**

Camper's Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: / / Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Phone: \_\_\_\_\_

**HEALTH EXAMINATION** ✓ = satisfactory X = unsatisfactory (explain) 0 = Not Examined

Height:		Weight:	
Eyes:	Lungs:	Posture:	Sensation:
Nose:	Heart:	Balance:	Circulation:
Ears:	Abdomen:	Coordination:	Nutrition:
Teeth:	Skin:	Spasticity:	Hernia:
Throat:	Extremities:	Motion Limits:	Genitalia:

Applicant's primary disability (Medical Diagnosis): \_\_\_\_\_

Secondary disability (if any): \_\_\_\_\_

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

Current Treatments: \_\_\_\_\_

### 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\*\***

### CURRENT PRESCRIPTION MEDICATIONS TO BE TAKEN AT CAMP:

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

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

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**

- |                                                    |                                                  |                                                     |                                             |
|----------------------------------------------------|--------------------------------------------------|-----------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Acetaminophen 325mg       | <input type="checkbox"/> Ibuprofen               | <input type="checkbox"/> Barrier Cream (Zinc Oxide) | <input type="checkbox"/> Eye Drops (Visine) |
| <input type="checkbox"/> Diphenhydramine HCL       | <input type="checkbox"/> Glycerin Suppository    | <input type="checkbox"/> Antacid (Tums)             | <input type="checkbox"/> Pepto Bismal       |
| <input type="checkbox"/> Hydrocortisone Cream      | <input type="checkbox"/> Triple Antibiotic Cream | <input type="checkbox"/> Aloe                       | <input type="checkbox"/> Nasal Decongestant |
| <input type="checkbox"/> Cold and Allergy Medicine | <input type="checkbox"/> Unisom (Sleep Aid)      | <input type="checkbox"/> Bacitracin Ointment        |                                             |

**ALLERGIES** (Food, Medication, Plants, Insects) \_\_\_\_\_

Reaction Type

- Anaphylaxis    Rash/Hives    Upset Stomach    Other: \_\_\_\_\_

**DIETARY RESTRICTIONS** Yes [ ] No [ ]

If yes, explain:

**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):

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

Bowel Habits: Frequency? \_\_\_\_\_ Preventive medications (e.g.: Miralax)? \_\_\_\_\_

Comments:

**PHYSICIANS STATEMENT**

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

[ ] 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

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

\_\_\_\_\_  
Licensed Physician's Signature

\_\_\_\_\_  
Physician Name (printed)

\_\_\_\_\_  
Date of Most Recent Examination

Physician Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: (     ) \_\_\_\_\_