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, 2022. For campers who did not attend camp Summer 2021 and are attending Weekend or Weeklong Camp this form must be completed prior to the first session the camper attends.

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*

(Voluntary) COVID vaccine date(s):_____ **Brand:**_____

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

☐ 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	

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 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 or health condition:

Allows [ ] Does Not Allow [ ] his/her participation in an active camp program.

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: ( ) _____