2020 Medical Examination Summary

Easterseals Tennessee Camp
500 Wilson Pike Circle, Suite 228
Brentwood, TN 37027
Phone: (615) 292-6640 ext. 2
Fax: (615) 251-0994

Date of Examination: _____

Date Form Completed: _____

APPLICANT'S NAME: _____ **Date of birth**: _____**Gender**:_____

IMPORTANT NOTE TO PHYSICIAN: The information requested in this form is extremely important to the applicant's health and safety during participation at Easterseals Camp. In most cases the level of activity will be higher than normal and the daily routine will be different. Camp has a health center on site staffed by a Camp Nurse; however, we are able to provide only routine, basic health care. It is crucial therefore, that care be taken in thoroughly completing this form. Thank you for your assistance in this matter.

PLEASE CHECK THE FOLLOWING:

Weight: _____ Height: _____ Blood Pressure: _____ Vision: _____ Hearing: _____

Eyes: _____ Ears: _____ Nose: _____ Throat: _____ Teeth: _____ Lungs: _____ Heart: _____

ABD.: _____ Gent.:_____ Skin: _____ Lymph Nodes: _____

Primary Diagnosis: (please be specific) _____ Date of Onsest:_____

Secondary diagnosis (related or unrelated to primary diagnosis):_____

Other Medical conditions (e.g. ileostomy):

_____

Any infectious diseases? Please name and give recommendations:

_____

Does the applicant have epilepsy? _____Type of seizures_____

Frequency: _____

Has the applicant been identified as developmentally delayed? _____ If yes please indicate level:

☐ Mild (IQ 69-55) _____ ☐ Moderate (IQ 54-40): _____ ☐ Severe/profound (IQ below 40): _____

DOES APPLICANT HAVE ANY ALLERGIES? _____ To:

☐ Bee Sting or insect bite ☐ Pollen ☐Serum: _____☐ Food: _____

☐ Drugs (penicillin, etc.): _____ ☐ Other: _____

Signs of allergic reaction:

_____

Recommended treatment:
_____

DIET: Does applicant have any medically prescribed meal plan or dietary restrictions? Please describe:_____
_____

CAMP ACTIVITIES: Please include any instructions or precautions to be taken during routine camp activities. These activities may include swimming, horseback riding, canoeing and sports:
_____
_____

Please list any activities in which the applicant may NOT participate:
_____
_____

Reactions that might be expected with irregularities in:

A. Environment
_____
B. Diet
_____
C. Medication
_____
D. Stress
_____

Medical History:

Dates of Immunizations:

Measles, mumps, rubella: _____ Tetanus-diphtheria Toxoid: _____ H. influenza: _____

Pneumonia: _____ Last TB Skin Test Date: _____

Results: _____

DPT series: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Polio series: 1. _____ 2. _____ 3. _____ Chicken Pox 1. _____

Hepatitis B: 1. _____ 2. _____ 3. _____

Last dates applicant has had:

Chicken pox: _____ Mumps: _____ Diphtheria: _____ German measles: _____

10 Day measles: _____ Whooping cough: _____ Strep throat: _____

Pneumonia: _____Rheumatic fever: _____ Mononucleosis: _____

Does applicant have a history of:

Ear infections: _____ Strep throat: _____ Gastric upsets: _____ Mono: _____
UTI: _____

Kidney problems: _____ Eczema: _____ Hypertension: _____ Diabetes: _____
Other: _____

Emotional upset: _____

SIGNATURE OF PRIMARY HEALTH CAREGIVER: _____

The following information could be crucial in an emergency situation. Please print or type clearly.

NAME OF PRIMARY HEALTH CAREGIVER: _____

ADDRESS: _____

CITY: _____ **STATE**: _____ **ZIP**: _____ **PHONE**: (___)_____

Medical professional to contact in the event applicant's Primary Health Caregiver cannot be reached:

Name and title: _____

Phone number: (___)_____

Address: _____