



Camp AmeriKids, Inc. (Camp AmeriKids)  
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## Camper Medical Application 2010

Camper's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

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

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

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Sex:  Male  Female SS#: \_\_\_\_\_

Child's Primary Caregiver (Name(s)): \_\_\_\_\_

Relationship to Child: Parent  Grandparent  Foster Parent  Adoptive Parent

Group Living Situation  Other Relative  Relation? \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ Other: ( ) \_\_\_\_\_

### EMERGENCY CONTACT NUMBERS

I authorize the following person(s) or agency to be contacted in the event of an emergency and I cannot be reached. I also authorize the following person(s) or agency to be contacted and authorize my child to be turned over to this person(s) if for any reason my child must leave camp or be picked-up at the bus stop if I am unavailable.

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Cell Phone: ( ) \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
Work Phone: ( ) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Cell Phone: ( ) \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
Work Phone: ( ) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Cell Phone: ( ) \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
Work Phone: ( ) \_\_\_\_\_

### INSURANCE INFORMATION (To be used in the event of an emergency)

\*\*\*Please attach a copy of the child's card\*\*\*

Insurance provider name, address, card number and sequence if applicable:

\_\_\_\_\_  
\_\_\_\_\_

**PHYSICIAN'S PHYSICAL EXAM FORM**

*These sections must be completed and signed by a physician*

Camper's Name: \_\_\_\_\_ DoB: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

Please list any current medical problem(s): \_\_\_\_\_

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**ALLERGIES** (medication or foods): Yes  No

Food: \_\_\_\_\_

Medications: \_\_\_\_\_

Seasonal: \_\_\_\_\_

Bee Sting Allergy: Yes  No  Poison Ivy Allergy Yes  No

Special nutritional requirements:

\_\_\_\_\_

\_\_\_\_\_

Restricted Activities:

\_\_\_\_\_

\_\_\_\_\_

**PAST MEDICAL HISTORY: (PLEASE ANSWER ALL QUESTIONS)**

Yes	No	Condition	Explain
		Asthma	
		Diabetes	
		Hypertension	
		Heart Disease (CHF, CAD, MI)	
		Heart Defects/Murmur	
		Seizures	
		Stroke/TIA	
		Ear/Sinus problems	
		Muscular/Skeletal Condition	
		Bleeding/Clotting Disorder	
		Fainting Spells	
		Thyroid Disease	
		Kidney Disease	
		GI Problems (abdominal, digestive)	
		Sickle Cell Disease	
		Sleep Disorder (Sleep Apnea)	
		Learning Disorder (ADHD, ADD)	
		Psychiatric/Psychological Disorder	
		Menstrual Problems (Female Only)	
		Other	

**PHYSICIAN'S PHYSICAL EXAM FORM CONTINUED:**

**Past Surgical History:** (Please list)

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Has child ever been hospitalized? Yes  No

If yes, please describe any serious hospitalizations:

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Please describe last hospitalization:

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**SPECIFIC MEDICAL IMMUNOLOGY INFORMATION**

Is the Child HIV +: Yes  No

If Yes, How was the child infected? Mother to child: \_\_\_\_\_ Other: \_\_\_\_\_

Most recent CD4 count: \_\_\_\_\_ Date: \_\_\_\_\_

Viral Load: \_\_\_\_\_ Date: \_\_\_\_\_

Has the child had any AIDS defining illnesses / Opportunistic Infections: Yes  No

Diagnosis: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date: \_\_\_\_\_

Chronic diarrhea: Yes  No  Has the child had Cryptosporidiosis: Yes  No

Please provide the most recent CBC: \_\_\_\_\_ Date \_\_\_\_\_

~~WBC~~  
~~Hb~~  
~~Hct~~  
~~Platelet~~

Differential: Neut: \_\_\_\_\_ Lymph: \_\_\_\_\_

Segs: \_\_\_\_\_ Monos: \_\_\_\_\_

Bands: \_\_\_\_\_ Eos: \_\_\_\_\_

Other Significant Abnormal labs: \_\_\_\_\_

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Recent CXR results: \_\_\_\_\_ Date: \_\_\_\_\_

Recent transfusions: \_\_\_\_\_ Date: \_\_\_\_\_

Product and dosage given: \_\_\_\_\_

**Does the child know his/her diagnosis: Yes  No**

If yes, how long have they known? \_\_\_\_\_

What terms does child use to describe their illness: \_\_\_\_\_

**PHYSICIAN'S PHYSICAL EXAM FORM CONTINUED:**

**IMMUNIZATIONS** (please attach a complete copy of up to date records)

MMR (x2) Yes  No  Date: \_\_\_\_\_

DPT (x4) Yes  No  Date: \_\_\_\_\_

Chicken Pox Yes  No  Date: \_\_\_\_\_

If no, has the child ever had clinical chicken pox? Yes  No  Date: \_\_\_\_\_

Influenza Yes  No  Date: \_\_\_\_\_

H1N1 vaccine Yes  No  Date: \_\_\_\_\_

Hepatitis B Yes  No  Date: \_\_\_\_\_

Last PPD: \_\_\_\_\_ Results: \_\_\_\_\_ if positive, please describe action taken:

\_\_\_\_\_

**DEVELOPMENT LEVEL:**

Age Appropriate  Mild Delay  Moderate Delay  Severe Delay

Please list any behavior problems that may affect participation in activities:

\_\_\_\_\_  
\_\_\_\_\_

List any medications taken for behavior: \_\_\_\_\_

**COMPLETE IF CAMPER HAS A CENTRAL VENOUS CATHETER OR OTHER DEVICES**

Type of catheter: \_\_\_\_\_ May line be used to draw blood? Yes  No

Please specify instructions for care of catheter (flush schedule, etc.): \_\_\_\_\_

Please specify any medications to be infused into this line during the camp period. \_\_\_\_\_

\_\_\_\_\_

Gastrostomy Tube (GT/JT): \_\_\_\_\_ Site: \_\_\_\_\_ Site care: \_\_\_\_\_

Formula for feeds: \_\_\_\_\_

Rate: \_\_\_\_\_ Duration: \_\_\_\_\_ Pump \_\_\_\_\_

How much help will camper need in caring for these devices: \_\_\_\_\_

**COMPLETE IF CAMPER HAS OXYGEN OR OTHER HOME MEDICAL EQUIPMENT NEED**

Oxygen needed: Yes  No  Continuously: \_\_\_\_\_ Nighttime: \_\_\_\_\_

Under these conditions: \_\_\_\_\_

O<sub>2</sub> flow rate: \_\_\_\_\_ Delivered via (mask, canula, prongs etc.): \_\_\_\_\_

Supplied in: \_\_\_\_\_ Other respiratory meds or therapies: \_\_\_\_\_

Home medical equipment company: \_\_\_\_\_

Phone: \_\_\_\_\_ Case Manager: \_\_\_\_\_

**PHYSICIAN'S PHYSICAL EXAM FORM CONTINUED:**

**PHYSICAL EXAM** (May attach a recent H&P in lieu of completing the following section)

Wt: \_\_\_\_\_ Ht: \_\_\_\_\_

BP: \_\_\_\_\_ HR: \_\_\_\_\_ RR: \_\_\_\_\_ O2 Sat% \_\_\_\_\_

System	Normal	Abnormal	Explain any Abnormalities
HEENT			
Heart			
Lungs			
Abdominal			
Extremities			
Neuro			
Musculo			
Skin			

Other pertinent physical exam findings:

\_\_\_\_\_  
\_\_\_\_\_

**PHYSICIAN INFORMATION**

I have examined \_\_\_\_\_ and find him/her to be physically able to attend camp. I understand the attached medical regimen will be followed while the camper is at camp (unless otherwise indicated on a "late changes" form).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (print): \_\_\_\_\_

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

Phone number: \_\_\_\_\_ Office: \_\_\_\_\_

Beeper: \_\_\_\_\_ Emergency: \_\_\_\_\_

**Physicians stamp:**