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Camper Medical Application 2012

Camper's Name: _____ Today's Date: _____

Sex: Male Female

Age: _____ Birth Date: _____ SS#: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Name(s) of Child's Primary Caregiver(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: _____

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

*****Please attach a copy of the child's insurance 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):

ALLERGIES (medication or foods): Yes No

Food Allergies: _____

Medication Allergies: _____

Seasonal Allergies: _____

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)

Has child ever been hospitalized? Yes No

If yes, please describe any serious hospitalizations:

Please describe last hospitalization:

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: _____

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: _____

} For New
Campers Only

Influenza Yes No Date: _____
Hepatitis B Yes No Date: _____

} For All
Campers

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: _____

O₂ 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: