MEDICAL INFORMATION

for: Camp Week _____

Camper _____

Birthdate _____

PARENT COMPLETED MEDICAL INFORMATION PART 1

CAMPER: _____ AGE: _____ SEX: _____ WEIGHT: _____

Camper's diagnosis: _____ Recent surgeries: _____

Any additional diagnosis: _____

Ill sib's, or parent's diagnosis: _____

Date of diagnosis: _____ Remission date (if any): _____

Physical restrictions / limitations, if any: _____

Special equipment (i.e.: wheelchair, braces, must be in good repair.) Wheelchairs MUST have seatbelts.

List any equipment used: _____

HEALTH HISTORY (to be filled out for ALL campers):

Any learning difficulties? Describe: _____

How does your child best understand instructions? _____

At what age level would you estimate your child functions? _____

Does your child have any emotional or behavioral difficulties? Describe: _____

Can they communicate verbally? _____

Are they potty trained/continent? _____ Do they wet the bed? _____ Can they feed themselves? _____

Allergies: _____ to foods _____

_____ to insects, plants, animals _____

_____ to medications _____

Convulsions / seizures (type and frequency): _____

List any dietary restrictions: _____

PLEASE ATTACH CURRENT IMMUNIZATION RECORD (*this must be attached to be able to attend camp)*

PLEASE ATTACH A COPY OF THE MEDICAL INSURANCE CARD *(if child is insured, this must be attached to be able to attend camp)*

RETURN THIS PAGE

PARENT COMPLETED MEDICAL INFORMATION PART 2

MEDICATIONS/TREATMENTS NEEDED AT CAMP

(to be filled out by the **parent**)

Camp Week _____

Name of Camper_____

Birthdate: _____ / _____ / _____

Parent phone (H) _____

(W) _____

The camp nurse will store and administer the medications and treatments listed below. It is expected that each family will supply any prescribed medications needed for their child. **Please bring a full week of medication to camp and review it with our med shed staff. You must bring pill bottles labeled with name and dosage. For Neuro week, a pill box is preferred as well.** Our med shed is stocked with emergency supplies.

CHILD'S DIAGNOSIS _____ **WEIGHT** _____
(primary & secondary)

MEDICATIONS (please list all medications, dosages, and home schedule)

	Medication Name	**Dosage**	**Time to be given**
1.			
2.			
3.			
4.			
5.			
6.			
7.			

ALLERGIES TO MEDICATIONS _____

*** is the child allergic to latex gloves? _____ Other allergies _____

_____

TREATMENTS/PROCEDURES (please tell us **exactly** how you do these)

*** spina bifida - - **separate sheet for bowel and bladder care to be sent**

Central venous catheter (Hickman, Broviac, Port) _____

_____

Glucose monitoring _____

_____

Factor infusions _____

_____

Other _____

_____

RETURN THIS PAGE

MEDICAL INFORMATION

for: Camp Week _____

Camper _____

PHYSICIANS PORTION MUST BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER (MD, NP, PA)

This child is an applicant for attendance at camp Carefree. if you are familiar with this child's medical history and current condition, a complete physical is not required. Please provide pertinent medical information requested. Information is for the use of our Camp carefree medical staff and any emergency providers during the child's time at Camp.

Name: _____ DOB: _____ Age: _____ Gender: _____ Weight: _____

Diagnosis (All): _____ Recent Surgeries: _____

Sibling/Parent Diagnosis (For Sibs/kids Week): _____

Physical Restrictions/Limitations, If Any: _____

Equipment Used: _____

Allergies: _____

Dietary Restrictions: _____

Cognitively Appropriate For Age? _____ If No, Please Comment: _____

_____

Any Additional Information (medical, social, behavioral) that may be pertinent to child's participation in Camp Carefree? _____

_____

_____

Does the child have any implanted devices - central line? _____

_____

PHYSICIAN'S STATEMENT: I hereby verify the above information concerning camper's medical history, health matters, immunizations and to the best of my knowledge, believe child is able to attend camp.

Physician's signature: _____ Phone: _____

Please print name: _____ Date: _____

PARENT PERMISSION STATEMENT: I give permission for this child to receive medications and/or treatment deemed necessary by Camp Carefree or emergency medical staff.

Parents signature: _____ Date: _____

Emergency phone number for parent: (W) _____ (H) _____

Other _____

Insurance Company _____

& Policy Number _____