SUBMIT THIS FORM TO Camp YouCan by August 4, 2014

HEALTH EXAMINATION and MEDICATION ORDER FORM

If there are medication changes made AFTER August 4th, please bring updated medication form to camp.

Camper's Name _____ Weight _____ Date Examined _____

To be filled out by physician:

In my opinion, the camper's condition ☐ does ☐ does not preclude his/her participation in an active camp program.
In addition to epilepsy, this child is under the care of a physician for the following condition(s):

_____

Comments/detail of above: _____

_____

Seizure Classification Type #1_____Type #2 _____

Type #3 _____Type #4 _____

Medication Name	Formulation Strength of tablet/capsule/liquid	Dose	Time of Day Given

***Physician: The above information will act as specific orders for camp staff to follow. Please enter as specific and detailed of information for medication, strength, dose and frequency. Please do not write statements such as "use as directed", etc. as abbreviations will not be accepted. Please include all medication the patient is taking, prescribed and over-the-counter, scheduled and as needed.

To your knowledge does this child have any significant emotional or behavioral problems? ☐ Yes ☐ No

Please be specific and advise. _____

_____

To your knowledge does this camper require assistive devices, such as, walker, helmet, braces, etc.?
If yes, please explain _____

_____

In your opinion, would the child successfully be able to participate in the following actions:

- **Understand and follow directions**
- **Stay involved in camp activities (activity periods are up to 2 hours in length)**
- **Interact in a respectful way with other campers and staff**
- **Participate in a day of mostly outdoor activities**
- **Be capable of independently performing activities of daily living (bathing, feeding, restroom use)**

☐ Yes ☐ No If no, please explain:

_____

_____

Licensed physician's signature _____

_____
Clinic name

_____
Address

_____
City State Zip

_____
Phone number physician can be reached at

Date of form completion: _____ *By:_____
Initial if completed by nurse or physician's assistant.