Camp Independence 2015 Season Medical Information - Form C

Must Be Completed By a Physician

Camper Information:

Camper's Name: _____DOB:_____AGE: _____ Gender: M / F
Primary Diagnosis: _____
Secondary Diagnosis:_____

Baseline Vital Signs:

Temp: _____ Pulse: _____Respirations:_____ Blood Pressure: _____ Height: _____
Weight:_____

Health History:

Please list any injury, illness, or infectious diseases within the last 6 months:
_____
Please indicate any chronic or reoccurring illness or conditions:
_____
Please indicate any hospitalizations and/or surgeries and dates occurred:
_____

Allergies:

Yes or No Medications If YES, which ones?
_____
Yes or No Foods If YES, which ones?
_____
Yes or No Insect bites If YES, how are reactions treated?
_____
Yes or No Pollen/Outdoors If YES, are reactions treated?
_____

Immunizations: Which of the following immunizations has the camper had?

Yes or No Measles Yes or No Chicken Pox
Yes or No German Measls Yes or No Mumps
Yes or No Hepatitis B Yes or No Hepatitis C
PDD: Date of last test:_____ Results? Positive or Negative
If positive, Date of last chest x-ray: _____ Results? Positive or Negative

Vaccine: Please indicate immunization dates Month/Year. An electronical print out of immunization record is acceptable.

DTP_____ TD_____ Tetanus_____
Polio_____ MMR_____ Influenza B _____
Hepatitis B _____ Varicella _____ Pneumonia_____
***Tetanus_____** Month/ Year of basic immunization _____ and of last booster_____.

*** All campers must have had a booster within the last 10 years to attend camp.***

Physical Assessment ('WNL's' represents within normal limits)
Psycho/Social System WNL'S
Any history of mental illness? _____
Currently in treatment for mental illness? _____
Comments_____
Cardio-Vascular System WNL'S
Any history of high blood pressure?_____
History of angina?_____
Comments_____
Respiratory System WNL's
History of Asthma?_____
Comments_____
Neurological System WNL's
History of seizures?_____
If Yes, Type of Seizures? _____
Shunt in place? _____
Date of Last Shunt Revision?_____
Comments_____
Skeletal System WNL's
History of joint pain?_____
Uses prosthesis? If so, what kind?_____
Activity restrictions?_____
Uses wheelchair? Yes or No Use crutches? Yes or No
Uses orthotics? Yes or No
Comments_____
Muscular System WNL's
History of muscular pain?_____
Contractures?_____
Comments_____
Integumentary System WNL's
Any rashes?_____
Comments_____
Endocrine System WNL's
History of Diabetes?_____
GI System WNL's
Feeding Tube? If so, provide orders_____
Comments_____
GU System WNL's
Independent or dependent bathroom skills? (circle one)_____
Bladder training program?_____
Incontinent or continent? (circle one)_____
Catheterization?_____if so, provide orders._____
Comments_____ _____
Reproductive system WNL's
Date of last menses? (if applicable)_____
Comments_____

Medications ***(Please include prescription, over-the-counter, and non-prescription drugs taken routinely.)***
This Camper takes **NO** medications on a routine basis.
OR
This Camper takes medications as follows:
Medication
(Type / Name)
Dosage
(mg/ ml)
How Administered
(mouth/ feeding tube/ crushed/ applesauce)
Frequency
(# /day)
Times
(AM/ Lunch/PM/ Bed)
• Please attach any additional pages as needed; endorse each with physician signature.

Over-Counter Medication

This is a list of over-counter medications that will be available to a camper while participating in Camp Independence. Please complete the information requested.
Camper (full name) _____ may have the following medication(s) as needed, while at camp. Medication will be given as directed on the label, unless otherwise instructed by physician.

(MUST CIRCLE YES OR NO FOR EACH OVER-COUNTER MEDICATION)

Tylenol* Yes or No **Cough Medication Yes or No**
Cold Medication Yes or No **Ibuprofen* Yes or No**
Laxative Yes or No **Antacid* Yes or No**
Anti-diarrhea Yes or No **Benadryl Yes or No**

* Indicates medication that is most often required
Please list any allergies: _____

I have examined the above camp applicant. Date examined:_____
Given the above medical information and restrictions, this person may participate in an active camp program designed for physically adults with physical disabilities.

Physician Signature: _____Date: _____
Physician Address:_____
_____
Physician Phone #:_____ Fax #:_____

DIRECTIONS FOR COMPLETION:
Step 1: Have Physician complete and sign.
Step 2: Mail To: **MossRehab at Elkins Park**
Attn: Sheneda Northcutt Secretary of Camp Independence
60 Township Line Road Elkins Park, PA 19027
or Fax To: 215-663-6417 Attn: Sheneda Northcutt.