MEDICAL INFORMATION

Camp Week: ____________________________
Name of Camper: ________________________
Birthdate: ___________/_________/_________

PARENT-COMPLETED MEDICAL INFORMATION: PART 1

CAMPER NAME: ____

AGE:__________GENDER: ____________ WEIGHT: ___________ HEIGHT: ___________

Camper's diagnosis: ____

Date of diagnosis: ____

Recent surgeries: ____

Any additional diagnosis: ____

Ill sibling's or parent's diagnosis: ____

Remission date (if any): ____

Physical restrictions / limitations: ____

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

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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 continent? _____________________

Do they wet the bed? __________ Can they feed themselves? _____________________________

Allergies to foods ____
To insects, plants, animals ____
To medications ____
Is the child allergic to latex? ____

Convulsions / seizures (type and frequency): ______________________________________

List any dietary restrictions: ____

PLEASE ATTACH CURRENT IMMUNIZATION RECORD including covid (*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)*

<u>PARENT-COMPLETED MEDICAL INFORMATION: PART 2</u>
MEDICATIONS/TREATMENTS NEEDED AT CAMP

Camp Week: ________________________
Name of Camper: ____________________
Birthdate: ________/_________/_________
Parent phone (H) ____________________
(W) __________________

Latest COVID VACCINATION DATE: ____________________________________

NOTE: We reserve the right to test anyone coming on Camp grounds for COVID, and may test all campers and counselors, depending on the risks and health conditions.

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 and first aid supplies.

CHILD'S DIAGNOSIS (primary & secondary): ____

____

HEIGHT: ___________ WEIGHT: ___________

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

<u>Medication Name</u>	**<u>Dosage</u>**	**<u>Time(s) to be given</u>**
1.		
2.		
3.		
4.		
5.		
6.		
7.		

TREATMENTS/PROCEDURES (please tell us **<u>exactly</u>** how you do these)
*** spina bifida: **<u>separate sheet for bowel and bladder care to be sent</u>**

Central venous catheter (Hickman, Broviac, Port): ____

Glucose monitoring: ____

Factor infusions/Hemophilia treatments: ____

Other: ____

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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: ____

Emergency phone numbers with names & relation:

______________ ________________ ____________________

Insurance Company: ____________________ Policy & Group Number:_______________

PHYSICIAN-SUPPLIED
MEDICAL INFORMATION

Camp Week: ________________________
Name of Camper:______________________
Birthdate: _______/_________/___________

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 weeks): ______________________________________

Physical Restrictions/Limitations, If Any: ____

Equipment Used: ____

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

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?
____

____

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 this child is able to attend camp.

Physician's signature:_____________________________Phone: ________________

Please print name:________________________________Date: _____________