CAMPER HEALTH FORM - 2015

Please complete both sides of this form

Please circle Camp(s) attending: **Carson** (July 13-17) / **Linden** (July 20-24)

Camper Name _____

Gender _____ Age _____ Name camper goes by _____
(for camper's name tag at camp)

Caregiver/Emergency Contact Information (Please provide up to 3 contact persons)
Note: Someone must be able to be contacted at all times during camp week.

Contact Name: _____ Phone: _____

Contact Name: _____ Phone: _____

Contact Name: _____ Phone: _____

IMMUNIZATIONS - Please check to verify that inoculations are current. Provide date, if known.

Tetanus _____ Polio Booster _____ Measles _____ Mumps _____

MEDICAL HISTORY/DRUG ALLERGIES - List and describe all current health issues, including any drug allergies.
Agencies: You may wish to attach the camper's Health Passport

_____

_____

SEIZURES - ( ) Yes ( ) No Date of last seizure: _____

What brings on a seizure? _____

Please describe a typical seizure, including duration, observable behavior, and measures that should be taken to ensure this camper's safety, and how they should be cared for following a seizure:

_____

SPECIAL EQUIPMENT/INSTRUCTIONS
Does this camper use any special equipment (i.e. C-Pap Machine; Oxygen; Catheter, etc.)? ( ) Yes ( ) No

If so, what equipment is used? _____

At check-in, you will need to provide written instructions for this equipment's use and demonstrate its use to Counselors

ALLERGIES/DIETARY NEEDS
Does camper have any food allergies or special diet needs? ( ) Yes ( ) No

If yes, please describe: _____

_____

Attach additional sheets, if necessary, to describe special dietary needs or allergy considerations

Is this camper diabetic? ( ) Yes ( ) No
If camper is diabetic, you will receive a call from the Camp Nursing Director

Nurse's Use Only
Date of call: _____

Over

MOBILITY

Special Friends Camp requires a lot of distance walking on uneven terrain. Please consider this as you describe your camper's abilities. The facilities and resources available at camp limit the number of wheelchair campers we can accept. The staff of Special Friends Camp reserves the right to determine that a camper is not mobility-appropriate for camp and the camper may be required to leave.

Does this camper walk independently without any aids? ( ) Yes ( ) No
If no, please describe camper's ability to walk _____

_____

_____

SELF HELP SKILLS

Is camper able to care for daily living skills? ( ) Yes ( ) No
Describe camper's abilities and level of assistance needed in showering, toileting, grooming, eating, etc.

_____

_____

ADDITIONAL INFORMATION

Please provide any additional information you think will be helpful for our Special Friends Camp staff to know. The more we know, the better care we can provide.
Agencies: You may wish to include the camper's Risk Assessment information.

MEDICAL RELEASE

I hereby give my permission to the Camp Director, Nurse, or designated staff to obtain x-rays, routine tests, treatment, and necessary related transportation for the above named camper. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to secure and administer treatment, including hospitalization for the above named camper. The completed forms may be photocopied for trips out of camp.

Responsible Party: _____ Date: _____

Relationship to Camper: _____

Medical Insurance Provider: _____ ID # _____

THIS SECTION MUST BE COMPLETED AND SIGNED BY PHYSICIAN

Date of last physical examination: _____ (must be within 12 months of camp)

This patient may participate in the Special Friends Camp program with the following limitations, if any.

_____

Physician's Name _____ Phone _____

_____ _____

Physician's Signature Date