

MAKE PROMISES HAPPEN

CAMPER MEDICAL AND INFORMATION FORM



Date of Application ____/____/____

Camp Attending _____

First Name _____ Last Name _____ Nickname _____

Sex ____ Age ____ Date of Birth ____/____/____

Primary disability? _____ Secondary disabilities? _____

Name of caregiver if accompanying camper to camp _____

If the camper has a special friend also coming to camp, list name below. We will try to put them in the same cabin.

(1) _____ (2) _____ (3) _____

Does camper need one-on-one assistance? YES ___ NO ___

If so, please explain _____

LANGUAGE AND COMMUNICATION: Please X all that applies.

No communication needs uses sign language uses communication device understands verbal instructions

eye gazes or uses eyes to communicate has difficulty being understood has difficulty speaking

Please describe any special words and phrases used at home. Any techniques that would help your child's counselor would be appreciated.

EQUIPMENT: Please X all that applies.

able to walk alone manual wheelchair electric wheelchair prosthesis needs assistance walking

needs assistance pushing wheelchair eyeglasses braces hearing aid

Please describe frequency of use of appliances. _____

Because of long walking distances, if the camper uses a walker or wheelchair part time, please bring it.

SLEEP HABITS:

Does the camper have any special sleep habits? (music, sleeps with stuffed animal, sleep walks, etc.)

EATING HABITS: Please X all that applies.

Independent Eater

Special Positioning (explain) _____

Other Concerns (equipment, special diet, food restrictions) _____

PERSONAL CARE: Please answer all questions by checking either YES or NO.

Independent in Toileting	YES___NO___	Independent Showering	YES___NO___
Needs Lifted onto Toilet	YES___NO___	Brushes Teeth by Self	YES___NO___
Have Bowel Control	YES___NO___	Dresses Independently	YES___NO___
Constipation Problems	YES___NO___	Catheter	YES___NO___
Have Bladder Control	YES___NO___	[] Self	[] Assisted
Needs Toilet Reminders	YES___NO___	Bears Weight w/Assistance	YES___NO___
Bed Wetting	YES___NO___ (if yes please send plastic bed cover, etc...)		

PLEASE BE SURE TO PROVIDE ENOUGH DIAPERS/DEPENDS/ AND UNDERGARMENTS.

Does camper avoid showers and bathing and need prompting? Are there special techniques used at home? Please describe: _____

SOCIAL CONCERNS:

Please comment about social skills (reactions to frustration, group participation, peer relations, response to supervision) _____

Please describe behavior and behavior plan _____

Does camper hit, bite, or inflict self-injury, etc.? (please describe) _____

Other information that you feel may be helpful? _____

PARENT/ CAREGIVER INFORMATION:

1st Parent/caregiver _____ Relationship _____ E-mail _____

Home Phone _____ Work Phone _____ Cell Phone _____

2nd Parent/caregiver _____ Relationship _____ E-mail _____

Home Phone _____ Work Phone _____ Cell Phone _____

EMERGENCY CONTACT INFORMATION:

If in the case of emergency, the parent cannot be reached, we ask that you give 2 additional names and numbers that we might contact. (pager and/or cellular phone numbers are acceptable)

Name _____ Phone Number _____ Relationship _____

Name _____ Phone Number _____ Relationship _____

INSURANCE:

Name: (Blue Cross/Blue Shield, etc...) _____ Medicaid Number _____

Company's Address _____

Policy Holder's Name _____ Policy/Group Number _____

Family Physician/ Medical Practitioner _____ Phone Number _____

Camper Full Name: _____

MEDICAL AND HEALTH CARE:

Height? _____ ft./in. Weight? _____ lbs.

Is the camper subject to? (Please X all that applies.)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Poison Ivy/Oak | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Swimmer's Ear |
| <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Urinary Tract Infections | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Severe Menstrual Cramps | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hepatitis Exposure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Insect Sting Reactions |

Does he/she have?

- | | | | |
|---|-----------------------------------|--|--|
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Rheumatic Fever |
|---|-----------------------------------|--|--|

Is he/she allergic to Penicillin? YES _____ NO _____

Has he/she been vaccinated for?

- | | | | |
|---------------------------------|----------------------------------|--------------------------------|----------------------------------|
| <input type="checkbox"/> D.P.T. | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Polio | <input type="checkbox"/> Tetanus |
|---------------------------------|----------------------------------|--------------------------------|----------------------------------|

Date of last Tetanus vaccination: _____

Has he/she been under the doctor's care in the last 12 months? YES _____ NO _____

If yes, please explain. _____

Are there restrictions on exercise? YES _____ NO _____

If yes, please explain. _____

Does he/she have any allergies to medications and/or food(s)? YES _____ NO _____

If yes, please list _____

AS NEEDED MEDICATIONS: Please mark X on the medications below your camper **IS NOT** allowed to take if needed.

For Pain, Fever, anti-inflammatory:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Acetaminophen (Tylenol) | <input type="checkbox"/> Ibuprofen (Motrin, Advil) | <input type="checkbox"/> Naproxen (Aleve) | <input type="checkbox"/> Acetylsalicylic Acid (Aspirin) |
|--|--|---|---|

For allergic reactions, sleep aide, motion sickness, nausea:

- | | |
|---|---|
| <input type="checkbox"/> Diphenhydramine Hydrochloride (Benadryl) | <input type="checkbox"/> Dimenhydrinate (Dramamine) |
|---|---|

For upset stomach, diarrhea:

- | | |
|---|---|
| <input type="checkbox"/> Bismuth Subsalicylate (Pepto-Bismol) | <input type="checkbox"/> Loperamide (Imodium) |
|---|---|

For heart burn:

- Antacid (Tums)

Topical Creams

- | | |
|---|--|
| <input type="checkbox"/> Hydrocortisone Cream | <input type="checkbox"/> Antibiotic Ointment |
|---|--|

