



Camper Name: _____

Medical Form (Campers)

SUBMISSION INSTRUCTIONS: This form is to be completed and signed by a licensed physician. The medical examination must be completed within 12 months of participation in Camp Promise programs. You must also complete page 3 of this form, which asks for a complete list of medical equipment and medications (including vitamins, herbal and over-the-counter medications) that you will be bringing to camp.

Name _____ Date of Birth _____ Age _____

Date of Examination _____ Gender Male Female Other

Primary Diagnosis _____

Other Diagnoses _____

Height _____ Weight _____ Temp _____ Pulse _____ Blood Pressure _____

Please list status, essential findings, deviation from normal:

ENT _____ GI _____

Lungs _____ Heart _____

Resp _____ Abdomen _____

Ears/Hearing _____ Mouth/Teeth _____

Neck/Thyroid _____ Skin _____

Lymphatics _____ Spine _____

Extremities _____ Emotional Status _____

If the camper is eighteen years of age or older, does the camper have the mental capacity to make appropriate decisions for him or herself? (Check One) Yes No

Does the camper have behavioral challenges? Yes No If yes, please describe the behavioral issues in detail (please use additional paper and include it with this form if necessary):

Could the camper's behavioral challenges affect the camper's ability to successfully attend Camp Promise and/or have a negative impact on other campers or staff? Yes No If yes, please describe the behavioral issues in detail (please use additional paper and include it with this form if necessary):

Please use this space to provide any additional information that Camp Promise should be aware of regarding the camper's behavior and physical, emotional, or mental health (please use additional paper and include it with this form if necessary):



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After examining the person herein described and reviewing their health history, **is it your professional opinion that this individual is medically, behaviorally & emotionally able to attend camp & engage in camp activities?**

(Check One) Yes No

If no, please explain (please use additional paper and include it with this form if necessary):

Does the camper have any allergies to medicine? Yes No Reaction/Notes _____

Does the camper have any allergies to food? Yes No Reaction/Notes _____

Does the camper have any allergies to anything else? Yes No Reaction/Notes _____

Does the camper require an epi-pen?

Does the camper take any medications? Yes No Reaction/Notes _____

(Please list medications on page 3)

Has the camper ever had a seizure? Yes No

If yes, please describe the following:

Please note the date of last seizure: _____

When do seizures occur? _____

How often do seizures occur? _____

How long do seizures last? _____

Characteristics of seizure: _____

Who should be notified if a seizure occurs? (check all that apply) Parent/Guardian Caregiver Physician

Recommendations and Restrictions for Camp Promise

Please describe any illness, injury, operations, or communicable diseases or conditions that relate to this individual's condition or care: _____

Are there any specialized treatments (outside of medication management, i.e. breathing, stretching, etc.) that need to be followed at camp?

Do you have any restrictions or recommendations for this camper while they are at camp (e.g., no participation in adaptive sports, no swimming, no boating, etc.)? (Check One) Yes No

If yes, please list _____

Over-The-Counter Medication Authorization

I hereby give permission for the camp medical staff to administer to the camper the following (or similar brand of) checked over-the-counter medications if deemed necessary. Dosages will be administered according to directions on the bottle unless a physician has directed otherwise. Check all that apply:

Acetaminophen Ibuprofen Benadryl Imodium AD Dulcolax/MiraLax Pepto Bismol/Pepcid AC/Tums

Fleet Enema Sudafed Hydrocortisone cream



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Camper Medication List

Camp regulations require that all camper medications must be documented on this form and administered by camp medical staff. This includes all prescription medications (such as antibiotics, birth control pills, asthma medications, insulin, etc.) and all non-prescription medications (such as allergy pills, cold tablets, vitamins, antacids, etc.) Medications **MUST** be turned in to the medical staff when the camper arrives at camp.

NOTE: Camp medical staff will only administer the medications listed on this form according to the Indication, Dose, and Times Given as described below. If a camper's medication regimen changes between submission of this form and the start of camp, it is their responsibility to update this form and notify the Camp Director.

Camp must bring enough medication for the full week of camp, plus two (2) additional days. All medications must be brought to camp in their original container(s) with original pharmacy label(s). While we encourage campers to continue all medications at camp, please also list any medications currently being taken by the camper that you've chosen, in consultation with the camper's treating physician, not to provide at camp. **Please use separate or additional sheets if necessary, but the physician MUST sign any & all additional pages. Physicians may also fill out this [Medication/Equipment List](#) if additional pages are needed, but ALL pages MUST be signed.**

Medication	Indication	Dose	Times Given (i.e. 2PM, 6PM, etc.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list the following medical equipment this camper will use at camp (feeding pump, leg braces, C-Pap, Bi-Pap, cough assist, oxygen, etc.). Please use additional sheets if necessary. **Physicians may also fill out this [Medication/Equipment List](#) if additional pages are needed, but ALL pages MUST be signed.**

Name	Time to be used	Description/Settings
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

A LICENSED PRACTITIONER (P.A. APRN, MD, DO) MUST SIGN IN THE SPACE PROVIDED BELOW. Practitioner may NOT be a member of the camper's family. I have examined the person herein described and reviewed his/her health history. It is my opinion that s/he is physically, emotionally, and behaviorally, able to engage in any required activities, except as may be noted above, and is free of communicable or contagious disease. I have also reviewed the above listed medication, equipment lists, and over-the-counter medication authorization and direct that they be provided to the named camp applicant as described above.

Signature of licensed practitioner: _____ Date _____

Printed Name _____ Phone Number _____

Address _____ City, State, Zip _____