

CAMPER HEALTH FORM - 2010 *

Please complete both sides of this form

Please circle Camp(s) attending: **Carson / Linden**

Camper Name _____

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

In case of emergency, notify _____

Daytime Phone _____ Evening Phone _____ Other Phone _____

Additional Contact Names and Numbers: _____

Note: Someone must be able to be contacted at all times during camp week.

IMMUNIZATIONS - Tennessee Department of Health requires current inoculations for Tetanus and Polio. Please check to verify that inoculations are current. Provide date, if known.

Tetanus _____ Polio Booster _____ Measles _____ Mumps _____

MEDICAL HISTORY - Circle the items that apply to this camper presently or in the past

Asthma	Sinusitis	Bronchitis	Kidney Trouble
Diabetes	Heart Trouble	Dizziness	Stomach Upset
Hay Fever	Ear Infections	Seizures	Emotional
Other - describe	_____		

List and describe all current health issues. **Agencies: If available, please attach the camper's Health Passport**

SEIZURES - () Yes () No Frequency _____

What brings on a seizure? _____

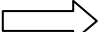
Please describe a typical seizure, including duration, observable behavior, and measures that should be taken to ensure this camper's safety: _____

Please describe how this camper should be cared for following a seizure: _____

ALLERGIES

Does camper have any allergies? () Yes () No

Please list all allergies to foods, drugs, insect bites and stings, etc. _____

Over 

MOBILITY

Does camper ever use any aids for walking? () Yes () No

Describe camper's ability to walk _____

READ THIS: *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.*

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.
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 _____

**This form must be submitted along with a Camper Application*