Physician's Form for Camp New Hope

Form must be filled out completely by Physician or Physician's Office and signed.

Return the ORIGINAL– DO NOT FAX. Information is gathered to assist in identifying appropriate care.
Return this form to parent or mail to Camp New Hope, PO Box 764, Mattoon, IL 61938

Camper Name: ______________________ Birthdate: __________ Age: ________ Sex: ☐ Male ☐ Female

Health History *Check applicable history*
- ☐ Frequent Ear Infections
- ☐ Heart disease/defect - **Explain:** ____________
- ☐ Seizure Disorder– **Explain in Seizure Box**
- ☐ Diabetes
- ☐ Bleeding/Clotting Disorders – **Explain:** ______
- ☐ HTN (High Blood Pressure)
- ☐ MRSA/VRE or Drug-resist infection: **Date cleared**?__________
- ☐ Measles/Mumps/Chicken Pox
- ☐ Axonal/Cervical Instability
- ☐ Heat Sensitivity
- ☐ TB Test Positive
- ☐ Allergies: (Please list) __________

DME/Other:
- ☐ Foley Catheter
- ☐ G-tube/J-tube
- ☐ CPAP/Bi-Pap/Apnea monitor
- ☐ Other: __________

Immunizations up to date? ☐ Yes ☐ No
Date of last Tetanus Vaccination: ____/____/____
If No, explain: ______________________

Diet:	Alterations:
☐ Regular	☐ Pureed
☐ Diabetic	☐ Mechanical soft
☐ NCS/LCS	☐ Mechanical soft meat only
☐ Gluten Free	☐ Honey-thick
☐ No added Salt	☐ Pudding thick

Food Restrictions/Allergies: ______________________

Does the camper have seizures? ☐ Yes ☐ No
What type? __________ Frequency __________
Are there any special treatments in addition to basic airway protection and safety precautions? Explain: ______________________

Pertinent History (Not included above): ______________________

Current Diagnosis: ☐ Cerebral Palsy ☐ Autism ☐ Down Syndrome
☐ Intellectual Disabil- ☐ ity: ☐ Mild ☐ Mod- ☐ erate Severe
☐ Speech Impairment: ☐ Verbal ☐ Hard to Understand ☐ Non-Verbal ☐ Sign Language/Signs ☐ Communication Device
☐ Visual Impairment: ☐ Blind ☐ Some Sight ☐ Night Blindness
☐ Hearing Impairment: ☐ Deaf ☐ Some Hearing ☐ Hearing Aides
☐ Behavioral Disorder: __________ ☐ Physical Limitations: __________
☐ Mental Illness: __________ ☐ Learning Disability: __________
☐ Other: ______________________

Any other special restrictions or considerations should be written here: ______________________

Medical Provider Statement:

I have examined the above camper applicant within the past year on ______________ (date of exam).
To my knowledge, the above named applicant has no conditions, including infectious diseases, which precludes his/her participation in an active camp program (unless otherwise noted) and his/her immunizations are up to date. Medications may be administered as stated by the guardian/parent/supervisor at check-in.

Licensed Provider Signature______________________ Printed Name: ______________

Address: ______________________ Phone: ______________

Date form completed: ______________ by Physician, APN/ PA, RN/LPN