

Physician's Form for Camp New Hope, Inc. (2018)

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:
<input type="checkbox"/> Regular	<input type="checkbox"/> Pureed
<input type="checkbox"/> Diabetic	<input type="checkbox"/> Mechanical soft
<input type="checkbox"/> NCS/LCS	<input type="checkbox"/> Mechanical soft meat only
<input type="checkbox"/> Gluten Free	<input type="checkbox"/> Honey-thick
<input type="checkbox"/> No added Salt	<input type="checkbox"/> 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 Disability: Mild Moderate 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