Physician's Form for Camp New Hope, Inc. (2019)

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 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