

MEDICAL REPORT FORM

****Complete when camper has been approved****

www.camphorizons.org -forms available on our website

Camp Horizons, Inc.
P. O. Box 323 South Windham, CT 06266
860-456-1032 fax: 860-456-4721

DATE OF PHYSICAL MUST BE WITHIN TWO YEARS OF ATTENDANCE

Camper's Name: _____ DOB: _____ Age: _____

Address: _____
(Street) (City, State) (Zip Code)

Medical Classification(s) _____

Significant past Medical History (including physical handicaps) _____

Is the camper taking any prescribed medications? Yes ___ No ___ (If yes, please complete front of ivory medication form.)

Is the camper using any over-the-counter medications? Yes ___ No ___ (If yes, please complete back of ivory medication form.)

Is this person subject to seizures? Yes ___ No ___ If yes, date of last seizure _____

Please describe seizures: When do they occur? _____ for how long? _____ how frequently? _____

When should parent/provider/physician be notified of seizure activity: after every seizure ___ after seizure lasting _____

Medication allergies? ___ If yes, list: _____

Other allergies? ___ If yes, list: _____

Can this person participate in the following activities (in agreement with guardian and white health history form):

-Horseback riding? Yes ___ No ___ (Helmet is provided) -Swimming? Yes ___ No ___ (Lifeguard is provided)

-Row-boating? Yes ___ No ___ (Lifejacket & lifeguards are provided)

Does this person need special considerations beyond general supervision within a 1:5 ratio during swimming, boating, horseback riding or any other activity? Yes ___ No ___ If yes, please explain _____

Please list any medical concerns or treatments to be monitored at camp:

Please describe any condition requiring immediate notification of parent/provider/physician:

Please describe any medically prescribed meal plan or dietary restrictions, including substitute foods:

Is the camper Hepatitis B. Positive? Yes ___ Antibody + ___ No ___ Unknown ___

Does the camper have HIV? Yes ___ No ___ Unknown ___

Does the camper have Atlantoaxial Instability? Yes ___ No ___ Unknown ___

Immunization History Required immunizations must be determined locally.

Please record the date of basic immunizations and most recent booster doses or provide immunization records.

Vaccines	Year of Basic Immunization	Year of Last Booster
DPT		
TD		
TETANUS		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Tuberculin test given _____ (most recent)		
Haemophilus Influenza B (HIB)		
Hepatitis B		
Varicella (Chicken Pox)		
Other		

Date of Physical Exam: _____

I certify that I have completed a physical examination of this person within the last two years on the date listed above. This person is in satisfactory condition to participate/work in an active residential camping program for and with people who have developmental disabilities. I am aware of all medications prescribed to this camper and see no contra-indications.

If camper should not receive one or more of the listed items, indicate by crossing through: (e.g. ~~Benadryl~~) This person may receive over-the-counter PRN medications and/or treatments in accordance with Camp Horizons' standing orders as deemed necessary by infirmiry staff and as permitted by absence of any known allergy.

Medication	Form	Medication	Form
Acetaminophen	Liquid/tablets	Immodium	Liquid/tablets
Aloe	Gel	Ipecac	Liquid
Aspirin	Liquid/tablets	Maalox	Liquid
Bacitracin	Cream	Midol	Tablets
Benadryl	Liquid/capsules	Milk of Magnesia	Liquid
Betadine		Mylanta	Liquid
Calamine or Caladryl	Lotion	Pepto Bismol	Liquid/tablets
Cough drops		Robitussin DM	Liquid
Epinephrine		Saline solution	Liquid
Hydrocortisone	Cream	Senakot	Liquid/tablets
Hydrogen peroxide	Liquid	Sudafed	Tablets
Ibuprofen	Liquid/tablets	Tinactin	Powder
		Tums	Tablets

PHYSICIAN/PRIMARY CARE PROVIDER'S SIGNATURE:

PHYSICIAN'S/PCP'S NAME PRINTED

ADDRESS

PHONE NUMBER