

MEDICAL FORM

MUST be signed & dated by a legal guardian & physician.

The League ~ Camping & Therapeutic Recreation

1111 E. Cold Spring Lane, Baltimore, MD 21239 ~ 410-323-0500

MUST BE COMPLETED WITHIN 1 YEAR OF ATTENDANCE!

Participants Name: _____ DOB: _____ Male: ____ Female: ____

Participants Address: _____
Street City/State Zip

Name of Legal Guardian: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell: _____

If the above named person is not available in the event of a medical emergency, please contact:

Name: _____ Relationship: _____

Day Phone: _____ Night Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____

Day Phone: _____ Night Phone: _____ Cell Phone: _____

HEALTH INSURANCE INFORMATION

Name of Health Insurance Company: _____ Group Number: _____

Policy Holder: _____ Policy Holder ID: _____

The League **MUST** have a copy of your insurance card on file. Insurance card attached ___ Yes; ___ No *Please mail in with this form.*

Primary Care Physician: _____ Phone: _____

HEALTH HISTORY

Please fill in with "yes" or "no" and if "yes" explain below.

____ Heart defect / disease	____ Frequent ear infections	____ Hay Fever	____ Chicken Pox	____ Food Poisoning
____ Diabetes	____ Mononucleosis	____ Poison Ivy	____ Measles	____ Other
____ High Blood Pressure	____ Asthma	____ Insect stings	____ Mumps	

"Yes" Explanations: _____

ASSISTIVE DEVICES

Eyes: Wears glasses: ___yes, ___no. Color of frame? _____

Ears: Wears hearing aids: ___yes, ___no. Level of support needed with them? _____

AFO: ___yes, ___no; Support needed? _____

Trunk Support: ___yes, ___no; Please describe: _____

Other Assistive Devices used: _____

MEDICAL CONDITIONS REQUIRING NOTIFICATION OF GUARDIAN & PHYSICIAN

OPERATIONS or SERIOUS INJURIES or MENTAL HEALTH CONCERNS

ALLERGIES

Medication Allergies (list): _____

Food Allergies (list): _____

Other Allergies (list) – may include insect stings, hay fever, etc.: _____

BOWEL PROGRAM Does the camper have any concerns regarding bowel movements? ____ yes ____ no

If yes, please describe the proper protocol to be performed below: *Be sure that any medication given as part of this program is listed on the Medication Form and brought to camp.*

ALCOHOL CONSUMPTION *For participants 21 and older*

Can this person consume alcoholic beverages? ____ yes ____ no

If yes, what is the number of acceptable beverages? ____ 12 oz. beer/5 oz. wine or ____ mixed beverages

SEIZURES Is this person subject to seizures? ____ yes, ____ no; if yes, date of last seizure: _____

Describe the seizure: Type: _____ How frequent? _____

Seizure triggers: _____ How long do the seizures last? _____

When should the guardian or physician be notified of seizure activity?

____ after every seizure; ____ after a seizure lasting more than ____ minutes; ____ no notice needed (please attach any special protocol)

SPECIALIZED HEALTH CARE PROCEDURES Does the participant require a specialized health care procedure during the program (i.e., nebulizer treatments, catheterization, etc)? ___ Yes; ___ No. If yes, please complete the following:

Name of procedure: _____

Description of procedure: *Please include time intervals between applications and conditions/symptoms that require repeating the procedure.*

Please list any precautions Health Center staff must be aware of before, during, or after the procedure:

IMMUNIZATIONS

REQUIRED Must be completed for adults ages 18 years and older, within the last five (5) years.	Date of Skin Test	Result of TB test
TB (Tuberculin) Test		

Vaccines *Required for everyone under the age of 18*	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)		
Haemophilus Influenza B (HIB)		
Hepatitis B		
Varicella		
Meningitis		
Other		

Please Note

If you have diabetes or utilize a G-tube; please call Kathy at 410-323-0500 ext. 309 for specific forms that need to be completed and signed by a physician in order to participate in Camping and Therapeutic Recreation programs.

Thank you in advance!

HEALTH CARE RECOMMENDATIONS FROM PHYSICIAN

Blood Pressure: _____ Weight: _____ Height: _____

This participant is able to participate in an active camp and/or therapeutic recreation program: ____yes; ____no

LIMITATIONS OR RESTRICTIONS ON CAMP ACTIVITIES:

MEDICAL CONCERNS/TREATMENT TO BE MONITORED AT CAMP:

MEDICALLY PRESCRIBED MEAL PLAN/DIETARY RESTRICTIONS:

⇒**Date of Physical Exam:** _____

I certify that I have completed a physical examination of this person within **one year** of the expected participation date, on the date listed above. This person is in satisfactory condition to participate in an active residential camping program for and with people with disabilities. I am aware of all medications prescribed to this camper and see no contra-indications. This person can also receive PRN medications/treatments when deemed necessary by Health Center staff and as outlined in The League's standing orders and the medication form.

⇒**PHYSICIAN SIGNATURE:** _____

Physician's Name/Title (printed): _____

Address: _____ Phone Number: _____ Fax Number: _____

PARTICIPANT AUTHORIZATION

I have reviewed this completed Medical Form. All information provided is correct to the best of my knowledge, and the participant herein described has permission to engage in all activities except as noted.

In case of emergency, I understand every effort will be made to contact me/the listed contact person. In the event that I cannot be reached, I hereby give permission to the Health Center staff to secure proper treatment, including hospitalization, necessary tests, anesthesia, surgery, or injections of medication for me/my child. Permission is given to transport me/my child for medical assistance. I understand that I am responsible for payment of all medical treatments received. This form may be photocopied for camp use.

By signing below I understand the above guidelines and agree to follow them.

Signature of Legal Guardian: _____ Date: _____

Printed name and relationship to participant: _____

FOR OFFICE USE ONLY:

Reviewed By: _____ Date: _____

**This form MUST be accompanied with the PINK MEDICATION FORM.
That must also be signed and dated by a physician and legal guardian within one year of attendance!**