Easterseals Camp Challenge
CAMPER MEDICAL FORM

(To be completed by a Licensed Medical Provider – 2 pages)

For Summer Camp this form must be signed by a licensed provider between April 1 and June 1, 2025.
For campers who did NOT attend camp Summer 2024 and are attending Weekend or Weeklong Camp this form must be completed prior to the first session the camper attends.

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY AND SIGNED & DATED TO BE VALID

Camper's Full Name:____
Address: ____
DOB: / / **Age:** ______ **Sex:**_______ **Weight:**__________

Applicant's primary disability (Medical Diagnosis): ___________________________
Secondary disability (if any): ___________________________
Applicant is under the care of a physician for the following condition(s):___________________________

____

IMMUNIZATION HISTORY
Does the camper have all the recommended vaccines? Yes [ ] No [ ] **Date of last Tetanus:** ____________________
If no, explain____
ALL eligible campers are ENCOURAGED to receive the COVID-19 vaccine*

ALLERGIES (Food, Medication, Plants, Insects) ___________________________
Reaction Type
☐ Anaphylaxis ☐ Rash/Hives ☐ Upset Stomach ☐ Other: ___________________________

DIETARY RESTRICTIONS Yes [ ] No [ ]
If yes, explain:
____
____

SEIZURES: Yes [ ] No [ ] Type ___________________________ Date of last seizure: ____________________
Known Seizure Triggers: ___________________________ Medication Controlled? Yes [ ] No [ ]
NOTES AND ADDITIONAL COMMENTS (please include any other information, including restrictions and limitations that we should be aware of):
____
____
____

BOWEL HABITS: Frequency? _______________ Preventive medications (e.g.: Miralax) ___________________________
Comments:
____
____
____

MEDICATION: All medications, both prescription and OTC must be listed on the next page. **NO medications (prescription or over-the-counter), supplements, or vitamins will be given without a doctor's order.**
Medication changes within the last 30 days? Yes [ ] No [ ] If yes, explain___________________________
____

Camper's Full Name:____

CURRENT PRESCRIPTION MEDICATIONS TO BE TAKEN AT CAMP: (Attach pages as necessary)

NAME	DOSAGE	TIME GIVEN	REASON FOR TAKING

CURRENT OVER THE COUNTER MEDICATIONS TO BE TAKEN AT CAMP: (Vitamins, OTC Allergy Medication, etc.)

NAME	DOSAGE	TIME GIVEN	REASON FOR TAKING

Camp Challenge medical staff routinely administer the following over-the counter medications. Please check all medications that may be given to the camper on an as-needed basis.

☐ Camper may have ALL of the medications listed below

☐ Acetaminophen 325mg ☐ Ibuprofen ☐ Barrier Cream (Zinc Oxide) ☐ Eye Drops (Visine)
☐ Diphenhydramine HCL ☐ Glycerin Suppository ☐ Antacid (Tums) ☐ Pepto Bismal
☐ Hydrocortisone Cream ☐ Triple Antibiotic Cream ☐ Aloe ☐ Nasal Decongestant
☐ Cold and Allergy Medicine ☐ Unisom (Sleep Aid) ☐ Bacitracin Ointment

PHYSICIANS STATEMENT

Can the camper safely be in a 1:3 staff to camper ratio? ☐ Yes ☐ No
Can the camper be outside for approximately 1 hour at a time? ☐ Yes ☐ No
Can the camper safely sleep overnight in a cabin environment? ☐ Yes ☐ No
Is the camper at excessive risk for dehydration? ☐ Yes ☐ No

I have examined the camp applicant. In my opinion, the camper's disability, health condition, and/or behavior:
Allows [ ] Does Not Allow [ ] his/her participation in an active camp program within the 1:3 staff to camper ratio.
The camper is specifically able to participate in the following activities:
[ ] Swimming (Shallow-Water Pool)
[ ] Outdoor Activities lasting 45-60 minutes
This medical form is used for year-round camping programs and valid for one year. Is the camper's health likely to remain stable during that time?* [ ] yes [ ] no
*An updated form may be requested prior to extended camping programs

____ ____
Licensed Physician's Signature Physician Name (printed)

____ ____
Date of Most Recent Examination Today's Date

Physician Address:____
City______________________________ State ________ Zip Code __________________
Phone: ( ) __________________________

Camper's Full Name:____