Medical Examination Summary

Easterseals Tennessee Camp
960 Simpson Maddox Pkwy, TN 37090
Phone: (615) 444-0597 ext. 420
Fax: (615) 444-9973

Date of Examination: ___________________________

Date Form Completed: __________________________

APPLICANT'S NAME: ___________________________ **Date of birth**: _______________ **Gender:**:________

IMPORTANT NOTE TO PHYSICIAN: The information requested in this form is extremely important to the applicant's health and safety during participation at Easterseals Camp. In most cases the level of activity will be higher than normal and the daily routine will be different. Camp has a health center on site staffed by a Camp Nurse; however, we are able to provide only routine, basic health care. It is crucial therefore, that care be taken in thoroughly completing this form. Thank you for your assistance in this matter.

PLEASE CHECK THE FOLLOWING:

Weight: _________ Height: ___________ Blood Pressure: ___________ Vision: _____________ Hearing: ____________

Eyes: _________ Ears: _________ Nose: _________ Throat: _________ Teeth: ________ Lungs: _______ Heart: ______

ABD.: _______ Gent.:_______ Skin: _______ Lymph Nodes: _______

Primary Diagnosis: (please be specific) ___________________________________ Date of Onset:______

Secondary diagnosis (related or unrelated to primary diagnosis):____

Other Medical conditions (e.g. ileostomy):

____

Any infectious diseases? Please name and give recommendations:

____

Does the applicant have epilepsy? _________ Type of seizures_____________________________________

Frequency: ____

Has the applicant been identified as developmentally delayed? __________ If yes please indicate level:

Mild (IQ 69-55) ______ Moderate (IQ 54-40): ______ Severe/profound (IQ below 40): ______

DOES APPLICANT HAVE ANY ALLERGIES? ___________ **Allergic to:**

Bee Sting or insect bite Pollen Serum: _________________________ Food:_______________

Drugs (penicillin, etc.): ____ Other: _________________

Signs of allergic reaction:

____

Recommended treatment:

____

DIET: Does applicant have any medically prescribed meal plan or dietary restrictions? Please describe:____

____

CAMP ACTIVITIES: Please include any instructions or precautions to be taken during routine camp activities. These activities may include swimming, horseback riding, canoeing and sports:

____

____

Please list any activities in which the applicant may NOT participate:

____

____

Reactions that might be expected with irregularities in:

A. Environment
____
B. Diet
____
C. Medication
____
D. Stress
____

Medical History:

Dates of Immunizations:

Measles, mumps, rubella: ________ Tetanus-diphtheria Toxoid: ____________ H. influenza: _________

Pneumonia: ______________ Last TB Skin Test Date: ____________________

Results: ____

DPT series: 1. ____________ 2. ____________ 3. ____________ 4. ____________ 5. ____________

Polio series: 1. ____________ 2. ____________ 3. ____________ Chicken Pox _________________

Hepatitis B: 1. ____________ 2. ____________ 3. ____________

Last dates applicant has had:

Chicken pox: __________ Mumps: __________ Diphtheria: __________ German measles: __________

10 Day measles: __________ Whooping cough: __________ Strep throat: __________

Pneumonia: _____________Rheumatic fever: __________ Mononucleosis: __________

Does applicant have a history of:

Ear infections: ___________ Strep throat: ___________ Gastric upsets:___________ Mono: ___________

UTI: ___________ Kidney problems: ____________ Eczema: ___________ Hypertension: ___________

Diabetes: ___________ Emotional upset: ___________ Other: ____________________________________

SIGNATURE OF PRIMARY HEALTH CAREGIVER: ____

The following information could be crucial in an emergency situation. Please print or type clearly.

NAME OF PRIMARY HEALTH CAREGIVER: ____

ADDRESS: ____

CITY: ____________________ **STATE**: _____ **ZIP**: __________ **PHONE**: __________________________

Medical professional to contact in the event applicant's Primary Health Caregiver cannot be reached:

Name and title: ____

Phone number: _________________

Address: ____