Camp Easterseals Virginia
900 Camp Easterseals Rd.
New Castle, VA 24127
Phone (540) 864-5750
Fax (540) 777-2194

MEDICAL EXAMINATION SUMMARY

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 Camp Easterseals. 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 camp nurses; however, camp is only able to provide routine, basic health care. Critical care medical facilities are one hour away. Therefore, it is crucial that care be taken in thoroughly completing this form. Thank you for your assistance in this important 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 applicant have epilepsy?_____Type of seizures:_____Frequency: _____

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

DOES APPLICANT HAVE ANY ALLERGIES? _____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: _____

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 which the applicant may NOT participate: _____

(over)

MEDICATIONS: *Please list all medications including dosage and times to be taken by the applicant. Medications are usually dispensed at mealtimes and bedtime, unless other times are indicated here as prescribed by physician.*

Medication	Dosage	Time	Medication	Dosage	Time

Idiosyncratic reactions to medications: _____

Reactions that might be expected with irregularities in:

A. Environment _____

B. Diet _____

C. Medications _____

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: 1._____

Hepatitis B: 1._____ 2._____ 3._____ Covid-19:_____

List 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:_____ Other:_____

Emotional challenges: _____

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 can not be reached:

Name and title:_____ Phone number: (_____)_____

Address: _____