Medical Form

This form must be completed and signed by the applicant's parent/guardian AND physician.
Physician review & signature may be required for new campers or returning campers with medical changes.

Name of applicant: _____ D.O.B. *(mm/dd/yy)*: _____

Diagnosis: _____

RCM provides staffing for basic personal care of individuals and has a designated Nurse on site for medical procedures and conditions. Do you agree this individual would be a good candidate for a camp in these controlled surroundings? Yes ☐ No ☐

Recommendations: _____

MEDICAL HISTORY: *Please check off all applicable boxes*

☐ Asthma ☐ Chest Pain ☐ Hay fever, Hives ☐ Severe Osteoporosis

☐ Heart Disease ☐ Hypertension ☐ Diabetic ☐ Insulin Dependent

If diabetic, please provide more information including regular levels, when to call 911, etc.

☐ Alzheimer

☐ Eczema

☐ Other derm. conditions

☐ GI concerns

☐ Headaches

Seizures: if YES, please describe last episode including date, type, duration, and frequency.
**If camper has a seizure protocol, this MUST be emailed to camp prior to camper's arrival.

Other Medical History:

ALLERGIES:

- ☐ **Drug** Allergies/Intolerance – Please specify: _____
- ☐ **Food** Allergies/Intolerance – Please specify: _____
- ☐ **Environmental** Allergies/Intolerance – Please specify: _____

Normal Blood Pressure: _____ Pulse: _____ ☐ Regular ☐ Irregular

MEDICATIONS: *Include prescriptions, over-the-counter drugs, herbal preparation, PRN's and vitamins*
All medications must be blister packed by a pharmacy. Medications not blister packed will NOT be administered at Camp.

Does the camper receive prescription medications? : ☐ Yes – please list (a current MAR must be provided by pharmacy with medications)
☐ No

Type	Dosage	Frequency	Time(s) given

All medications are administered by the Registered Nurse at 08:00, 12:00, 17:30, and 21:00 unless otherwise directed by physician or pharmacist on medication.

PRN medications (if needed) that may be administered to Applicant at camp are:
Please check off applicable PRN's.

☐ Tylenol (Acetaminophen) 1-2 tabs q 4-6 h prn - Adult ☐ Children's ☐
☐ Tylenol for Menstrual Cramps 1-2 tabs q 4-6 prn Imodium ☐ Senokot (Laxative) 1-2 tabs BID prn
☐ (Loperamide) as per pkg. recommendations ☐ Tums
☐ Gravol (Dimenhydrinate) 1-2 tabs q 4-6 h prn ☐ Polysporin
☐ Robitussin liquid as per bottle recommendations ☐ After Bite
☐ Benadryl Crème as per pkg. recommendations ☐ Allergy Aid 1-2 tabs q 6 h prn
☐ Benadryl liquid for children as per bottle recommendations (Diphenhydramine)
☐ Advil (Ibuprofen) 1-2 tabs q 4-6h prn - Adult ☐ Children's ☐
☐ Restorolax

Current Weight: ☐

Camp Nurse protocol requires that contact with applicant's physician is needed if PRN's need to be administered at camp and are not checked off.

ACTIVITIES: All activities are supervised, with RN present. Is this applicant medically fit to participate in the following activities?

Swimming	☐	Yes	☐	No	
Long walks	☐	Yes	☐	No	
Other sport/games	☐	Yes	☐	No	

What precautions would you recommend?

Physician's other recommendation of behalf of the applicant?

I believe all information submitted in this form is accurate, and that Rehoboth Christian Ministries representatives have full right to rely on this information while the applicant participates in the camp program

Dated this _____ of _–_____–, 20__

Physicians' Name _____

Print name

_____

Signature

Address:

Contact Number: Alternate Number:

Dated this _____ of _–_____–, 20__

Guardian Name _____

Print name

_____

Signature
