

2008 Season
Camp Independence Medical Information - Form C
TO BE COMPLETED BY A PHYSICIAN

(Please use additional pages if necessary)

Camper's Name: _____

Physician's Name: _____

Physician's Address: _____
Street City State Zip

Physician's Telephone: _____

Explain patient's disability(s): _____

Current medical problems: _____

Recent hospitalizations (include dates): _____

Recurrent medical problems (i.e. autonomic dysreflexia, hypertensive crisis, UTI, pneumonia) Include treatment: _____

Has patient's medical condition changed within the last year? No ___ Yes ___ If yes, please explain: _____

Is patient restricted from any physical activity? No ___ Yes ___ If yes, please explain: _____

Does patient have a seizure disorder? No ___ Yes ___ Frequency of sz: _____

Longest duration of sz: _____ Factors precipitating sz: _____

List present medications, attach additional info PRN. Are they self-administered? No ___ Yes ___

Name of Medications	Dosage	Route	Schedule & Duration
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all allergies (Drugs/foods/animals, etc.): _____

List special diet restrictions: _____

Vital signs: BP range: _____ HR range: _____ RR range: _____ Weight: _____

Menstruation normal? N/A ___ Yes ___ No ___ If no please explain: _____

Tetanus Vaccine: Month & Year of basic immunization _____ and of last booster _____

All campers must have had a booster within the last 10 years to attend camp.

I have examined the above camp applicant. Date examined _____

Given the above medical information and restrictions, this person may participate in an active camp program designed for physically disabled adults. Licensed Physician's signature _____

Please Return To: Camp Independence/Therapeutic Recreation Department
MossRehab
60 East Township Line Road
Elkins Park, PA 19027
Fax 215.663.6417 or email to: Kelokdah@einstein.edu