Camp Horizon 2018

MEDICAL FORMS

A **physician** must complete & sign these forms.

These forms may be returned later than the camp application, but *must be received by* ***June 1, 2018***

Results of a physical exam cannot be accepted as a replacement for these forms.

Campers will not be able to attend camp if we don't have these forms, so please be sure to have them completed by a physician in a timely manner.

Return completed medical forms to:

Patricia Coale, Director of Therapeutic Recreation
The Up Center
222 W.19th Street
Norfolk VA 23517

theUPcenter
UNDERSTANDING PEOPLE UNLEASHING POTENTIAL
SINCE 1883

Medical Authorization for Participation in Camp Horizon

MUST be completed and SIGNED BY PHYSICIAN.

NAME _____ DATE OF BIRTH _____ AGE _____

Primary Diagnosis _____ Secondary Diagnosis _____

Is the above individual medically cleared to participate in the following camp activities: If no, please explain.

	YES	NO	EXPLAIN
Pool activities (indoor)	___	___	_____
Aerobic exercise	___	___	_____
Running	___	___	_____
Team sports	___	___	_____
(baseball, basketball, soccer, etc.)			_____
Outdoor games	___	___	_____
Field trips	___	___	_____
Cooking	___	___	_____
Arts & Crafts	___	___	_____

Medical Conditions Check all conditions that apply to the individual named above and make comments concerning potential health and safety issues.

		Comments
Heart Disease/Disorder	___	_____
Diabetes	___	_____
Asthma	___	_____
High Blood Pressure	___	_____
Headaches	___	_____
Heat/Sun Sensitivity	___	_____
Balance/Coordination	___	_____
Physical Impairments	___	_____
Surgery/Hospitalization/	___	_____
Serious Illness	___	_____
Other _____	___	_____

I hereby give my approval for the aforementioned individual to participate in Camp Horizon.

_____ _____

Physician's Name (please print) ***Phone***

_____ _____

Physician's signature ***Date***

Adult campers or parent/guardian should also sign:

I have read and understand this form and agree to adhere to any and all specific precautions recommended by the physician. I further agree that should the physical condition or medication of the aforementioned individual change in any way (i.e. hospitalization or re-diagnosis), I will immediately notify The Up Center – Camp Horizon.

_____ _____

Adult camper or Parent/Guardian signature ***Date***

Seizure Information Form

Camper's Name _____Completed by: _____

Does camper experience seizures? yes no If yes, usual duration _____

If yes, describe applicant's seizures so that staff will be aware of actual seizure activity if it occurs during camp.

Mental Status	Comments
Unchanged	_____
Dreamlike	_____
Vacant	_____
Unconscious	_____

Muscle Tone Change	
Rigid, whole body	_____
Right arm, leg; Left arm, leg	_____
Limp	_____
Falls down	_____

Movement	
Jerks; whole body	_____
Right arm, leg; Left arm, leg	_____
Jacknifes	_____
Purposeful movement	_____
Head drop	_____

Color	
Flushed	_____
Pale	_____
Bluish	_____

Mouth	
Salivates	_____
Chews	_____
Swallows	_____
Smacks lips	_____
Cries	_____
Talks	_____

Sphincter	
Urinates	_____
Defecates	_____

Eyes	
Turns right	_____
Turns left	_____
Rolls up	_____
Pupils change size	_____

Breathing	
Stops for: (enter seconds)	_____
Becomes noisy	_____

Behavior After	
Irritable	_____
Confused	_____
Drowsy	_____
Deep sleep	_____
Normal	_____

Camp Horizon Policy Regarding Medications

1. A DOCTOR'S ORDER IS REQUIRED
   For all meds (prescription and over-the-counter)

   - Have your doctor sign & complete the medication form or provide legible, written prescriptions.

   - This includes over-the-counter medications. **We must have a doctor's order to give** aspirin, Tylenol, ibuprofen, vitamins, lotions, ointments, etc. to campers.
     If there is any possibility camper will need any of these products at camp (i.e. for a headache), make sure to have the physician complete & sign the form..

2. Medications must be IN THE **ORIGINAL** CONTAINERS with:

   - Name of person receiving medication
   - Dosage & name of medication
   - Name of prescribing physician
   - Expiration date

3. Bring only the **EXACT NUMBER OF PILLS NEEDED AT CAMP**
(include no more than 2 extra pills if desired to allow for dropped pills.)

[Retain additional medications at home in containers you have saved from previous prescription refills or ask your pharmacy to give you extra containers with the prescription labels].

Camp Horizon

PRESCRIPTION & OVER THE COUNTER MEDICATIONS

Physician's Orders/Medication Release Form

Camper's Name _____

Medication	Dosage (in mg)	Administration Time(s)	Special Directions (i.e. with water, crushed in food, etc.)

Physician's Name (printed) _____

PHYSICIAN'S SIGNATURE _____ Date_____

I, _____(parent or legal guardian) do hereby authorize a representative of The Up Center to administer prescription medications as described below to _____. (camper). While I understand that every effort will be made to comply with my exact instructions, I release The Up Center and its staff from liability for any accident, incident or injury that may occur as a result of administering above medications.

Parent/Guardian/Adult Camper _____Date _____