Camp Krem MED FORM 2010

Return completed form to:
4610 Whitesands Court
El Sobrante, CA 94803
Phone number: (510) 222-6662
Fax number (510) 223-3046

MUST BE COMPLETED BY PARENT OR GUARDIAN AND PHYSICIAN. – SUBMIT BY DUE DATE WITH COPY OF MEDICAL INSURANCE CARD.

Due Dates: **Session 1, 4/25 Session 2, 5/2 Session 3, 5/6 Session 4 , 5/10 Session 5, 5/15 Session 6, 5/20**

Camper Name_____ **DOB** ____/____/____

PARENT / GUARDIAN MUST READ AND SIGN BELOW: I, the undersigned, hereby represent that I am the parent or legal guardian of my camper, and state that the health history is true and correct so far as I know. In the event of sickness or accident, Camping Unlimited will not be held responsible for acts or omissions of third parties, or for its own reasonable acts or failures to act. I agree that he / she may participate in Camping Unlimited programs. With the realization that, personal notification may not be possible or practicable, I authorize Camping Unlimited to render any aid or assistance to help my camper including calling a physician, radiologist, surgeon or dentist, if necessary, who may take any measure, including surgery and hospital care, deemed necessary to help my camper. I give the staff of Camping Unlimited permission to give medication to my camper. I agree to pay for any prescribed medication or treatment my camper may need. Further, I agree that my camper may be photographed while participating in the Camping Unlimited program with the understanding that photos may be used for publicity purposes. I give my permission for my camper to be transported off camp property when necessary. This authorization shall continue to be in effect as long as my camper is a participant in the Camping Unlimited program. I will notify Camping Unlimited if there are any changes to my camper's medications or medical needs prior to my camper attending camp. I will contact Camping Unlimited if there are changes in camper's social/behavioral status which may necessitate an increased level of supervision other than a 1:2 ratio.

****** PARENT/GUARDIAN SIGNATURE** _____ **DATE**_____
CAMPER SIGNATURE IF OVER 18 AND OWN GUARDIAN _____ **DATE**_____

***MEDICATIONS: If your camper must take medications, vitamins or supplements at camp, they must be listed on this form and reviewed by Doctor.** Medications must be sent to camp in original prescription containers or bubble-packed. If medications are not on this list signed by the doctor, (**including over the counter medications**), the camp nurse **cannot** give the medication. If there is a change after this form is submitted, the nurse must have a note from the doctor stating the change. If camper needs medications during bus time, give Bus Monitor a separate sealed envelope in bag with camper's name. LIST ADDITIONAL MEDICATIONS ON SEPARATE PAPER **SIGNED BY PHYSICIAN**.

IMPORTANT: Please note that at certain times, some medications will be administered by unlicensed staff who will have been instructed by the nurse.

MEDICATION NAME	DOSEAGE	FREQUENCY	REASON FOR TAKING	SPECIAL NOTES BY CAMP KREM STAFF

MD INITIALS _____

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Camper Name _____ DOB ____/____/_____

PHYSICAL EXAM: DOCTOR MUST COMPLETE AND SIGN : Doctor please review above medication and allergy lists for accuracy before signing.
Because we are a camp for people with developmental disabilities, **YOU MUST LIST WHAT THE CAMPER'S DEVELOPMENTAL DISABILITY AND ANY MEDICAL DIAGNOSIS ARE:**
Developmental Disability: _____
Medical Diagnosis 1: _____
Medical Diagnosis 2: _____
Medical Diagnosis 3: _____
Please list any further medical diagnoses on separate page.

Blood Pressure ____ / _____Weight _____Height_____Temp____ Pulse_____Resp: Implants? Yes/No: Type_____

All TB tests must be within 12 months of camp ending date. If PPD not indicated, please initial below.

PPD neg/pos date_____ **OR** This camper is not at risk and/or shows no symptoms of tuberculosis. Therefore a PPD is not necessary. **MD INTIALS _____**
Sleep Machine? Yes/No: Type_____
List Any Allergies:_____ History of Seizures Yes/No
Type of Seizures _____ Date of last seizure: __/___/____
Frequency and duration _____
Please describe camper's seizure activity/when to call MD or parent.
_____
_____
Medically prescribed meals or dietary restrictions?_____
Recent Health Problems:
_____
_____

SYSTEM	NORMAL	ABNORMAL	DESCRIBE
EYES			
EARS			
NOSE/THROAT			
SKIN			
CARDIOVASCULAR			
REPIRATORY			
ABDOMINAL			
NEUROLOGICAL			
MUSCULOSKELETAL			

STATEMENT OF PHYSICIAN: I examined camper_____
on _____/ _____/_____/ and found no evidence of communicable disease and found him/her to be in satisfactory condition to participate in camp programs to:
A: _____ FULL EXTENT WITHOUT RESTRICTIONS B: _____ With restrictions _____ Please list restrictions/reasons for restrictions
_____

******DOCTOR SIGNATURE_____ DATE SIGNED _____
OFFICE PHONE (____)_____ MD ADDRESS _____