

2018 CHRISTIAN OVERCOMERS CAMP

MEDICAL INFORMATION

July 09-13

August 19-24

October 08-12

CAMPERS INFORMATION:

NAME= _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SS#: _____ GENDER: _____ BIRTHDATE: _____

HOMEPHONE: _____

CIRCLE ONE: GROUP HOME PRIVATE RESIDENCE FACILITY SUPPORTIVE LIVING

HEALTH HISTORY

HEIGHT: _____ WEIGHT: _____

HAS CAMPER HAD ANY SERIOUS SURGERY? YES _____ NO _____

IF YES EXPLAIN: _____

WHAT IS YOUR DISABILITY? _____

HAS A PHYSICIAN DISCOURAGED/LIMITED YOUR ACTIVITIES? YES _____ NO _____

IF YES EXPLAIN: _____

IF ADAPTIVE EQUIPMENT NEEDED PLEASE SEND WITH CAMPER

DOES CAMPER HAVE ANY DIETARY MODIFICATION/RESTRICTION? YES _____ NO _____

IF YES EXPLAIN: _____

PLEASE CIRCLE ALL THAT APPLIES:

FREQUENT EAR INFECTION

ASTHMA

BLEEDING DISORDER

FREQUENT HEADACHE

BEDWETTING

SLEEP WALKING

HYPERACTIVITY

HYPERTENSION

EPILEPSY/SEIZURES

HEART DEFECT

CONVULSION

DOES CAMPER HAVE ANY ALLERGIES? YES _____ NO _____

IF YES CIRCLE: POISON IVY HAY FEVER FOOD ALLERGIES BEE STINGS

PENICILLIN

OTHERS PLEASE LIST: _____

DATE OF LAST TETANUS SHOT: _____

WHAT OTHER MEDICAL INFORMATION WILL BE HELPFUL TO STAFF AND NURSE? _____

CAMPER'S NAME _____

MEDICAL/HOSPITAL INSURANCE _____

POLICY NUMBER _____

PHYSICIAN NAME _____ PHONE _____

DATE OF LAST PHYSICAL _____

SEND CAMP CONFIRMATION MATERIAL TO: (IF DIFFERENT THAN ABOVE)

RELATIONSHIP TO CAMPER _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ E-MAIL _____

PERSON RESPONSIBLE FOR TRANSPORT TO AND FROM CAMP

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ E-MAIL _____

IN CASE OF EMERGENCY NOTIFY

RELATIONSHIP TO CAMPER _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ E-MAIL _____

SEIZURES

SEIZURES? YES _____ NO _____ DATE OF LAST SEIZURE _____

WHAT IS FREQUENCY OF SEIZURES? _____

IS CAMPER ON SEIZURES MEDICINE? YES _____ NO _____ PLEASE LIST:

PLEASE DESCRIBE CAMPER'S ABILITIES AND ASSISTANCE NEEDED: CIRCLE

MOBILITY:	INDEPENDENT	NEED ASSISTANCE W/BALANCE	WALKER
	CRUTCHERS	CAN ONLY WALK SHORT DISTANCE	WHEELCHAIR
VISION:	NORMAL	LEGALLY BLIND	WEARS GLASSES
	WEARS CONTACTS		
HEARING:	NORMAL	HEARING IMPAIRED	DEAF
ASSISTIVE DEVICES:		NONE	HELMET
	BRACES	PROTHESIS	
SLEEPING:	BED BLOCKS	HOYER LIFT	
PERSONAL HYGIENE:		NO ASSISTANCE NEEDED	REMINDER/VERBAL CLUES ONLY
	ASSISTANCE IN / OUT OF SHOWER		
PARTIAL ASSISTANCE WITH:		BRUSHING TEETH	STYLING HAIR
	WASHING UPPER BODY	WASHING LOWER BODY	WASHING FACE SHAVING
		DRYING OFF	TOILETING COMMODE
BLADDER / BOWEL:		ALWAYS IN CONTROL	SOMETIMES IN CONTROL
		NEEDS REMINDER	INCONTINENT
		BOWEL REGIME	

IF PERSONAL HYGIENE ASSISTANCE IS NEEDED PLEASE EXPLAIN IN DETAIL HOW STAFF OR VOLUNTEER CAN HELP: _____

EATING:		NO ASSISTANCE NEEDED	SOME ASSISTANCE NEEDED
	FOOD CUT UP	FOOD BLENDED	USE STRAWS
DIET CONTROL:		LOW CALORIE	DIABETIC
		LACTOSE INTOLERANT	THICK LIQUIDS ONLY

FOOD ALLERGIES: _____

FLUID/FOOD RESTRICTION: _____

MEDICATIONS: PLEASE ATTACH SEPARATE SHEET IF NECESSARY

MEDICATION _____ DOSAGE PER DAY _____
MEDICATION _____ DOSAGE PER DAY _____
MEDICATION _____ DOSAGE PER DAY _____
MEDICATION _____ DOSAGE PER DAY _____
MEDICATION _____ DOSAGE PER DAY _____
MEDICATION _____ DOSAGE PER DAY _____

MENTAL ABILITY & SOCIAL INTERACTION SKILLS:

CAMPERS MENTAL ABILITY: CIRCLE ONE

- MILDLY MENTALLY IMPAIRED
- MODERATELY MENTALLY IMPAIRED
- SEVERELY/PROFOUNDLY MENTALLY IMPAIRED

DESCRIBE THE NATURE OF THE CAMPERS DISABILITY: _____

IS CAMPER VERBAL OR NOVERBAL? VERBAL _____ NON VERBAL _____
DOES CAMPER HAVE DIFFICULTY EXPRESSING THOUGHTS AND OR WANTS? YES _____ NO _____
IF YES HOW CAN COMMUNICATION TAKE PLACE? _____

DESCRIBE CAMPERS BEHAVOIR BY CIRCLING:

- | | | |
|----------------------------------|--|-----------------------|
| NO UNUSUAL BEHAVIOR | VERBALLY AGGRESSIVE | PHYSICALLY AGGRESSIVE |
| WITHDRAWN/SHY | WANDERS AWAY | TEMPER TANTRUMS |
| HOME SICKNESS | ATTACHES SELF TO MALE STAFF/VOLUNTEERS | |
| ATTACHES FEMALE STAFF/VOLUNTEERS | | |

IF BEHAVORIAL PROBLEMS ARISE, HOW SHOULD STAFF DEAL WITH PROBLEM? _____

PHYSICIAN SIGNATURE _____ **DATE** _____

CAMPERS SIGNATURE _____ **DATE** _____

Please return all forms to Christian Overcomers, PO Box 2007, Garfield, NJ 07026

Any question call 973-253-2343