2017 CHRISTIAN OVERCOMERS CAMP

MEDICAL INFORMATION

July 10-14 August 20-25 October 9-13

CAMPERS INFORMATION:

NAME= _____ _____

ADDRESS:

_____

CITY:_____STATE:_____ZIP:_____

SS#:_____GENDER:_____BIRTHDATE:_____

HOME PHONE: _____ _____

CIRCLE ONE: GROUP HOME PRIVATE RESIDENCE FACILITY SUPPORTIVE LIVING

HEALTH HISTORY

HEIGHT:_____WEIGHT:_____

HAS CAMPER HAS 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 PENCILLIN

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_____

PHYSICAN 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 ASSSISTANCE 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
ASSISISTIVE 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

MIDLY 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