



# + CAMP KETCHA MEDICAL FORM (CONTINUED) +

## MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person **takes NO medications** on a routine basis. OR  This person **takes medications** as follows:

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
 Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_  
 Reason for taking \_\_\_\_\_

Attach additional pages for more medications.  
 Identify any medications taken during the school year that participant does/may not take during the summer: \_\_\_\_\_

## RESTRICTIONS (The following restrictions apply to this individual.)

**Does not eat:**  Red meat  Pork  Dairy products  Poultry  Seafood  Eggs  Other (describe) \_\_\_\_\_

**Explain any restrictions to activity** (e.g. what cannot be done, what adaptations or limitations are necessary) \_\_\_\_\_

## GENERAL QUESTIONS (Explain "yes" answers below.)

	Yes	No		Yes	No
Has/does the participant:					
1. Had any recent injury, illness or infectious disease? .....	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition? .....	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints (e.g., knees, ankles)? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized? .....	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery? .....	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems (e.g., itching, rash, acne)? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury? .....	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma? .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious? .....	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the past 12 months? .....	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eye wear? .....	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/constipation? .....	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections? .....	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking? .....	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history? .....	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting? .....	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures? .....	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise? .....	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought? .....	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur? .....	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the questions. \_\_\_\_\_

Which of the following has the participant had?

- Measles
- Chicken pox
- German measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

TB Mantoux Test

Date of last test \_\_\_\_\_

Result:  Positive  Negative

Please give all dates of immunization for:

Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP		_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
Tetanus		_____	_____	_____	_____	_____	_____
Polio		_____	_____	_____	_____	_____	_____
MMR		_____	_____	_____	_____	_____	_____
or Measles		_____	_____	_____	_____	_____	_____
or Mumps		_____	_____	_____	_____	_____	_____
or Rubella		_____	_____	_____	_____	_____	_____
Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Hepatitis B		_____	_____	_____	_____	_____	_____
Varicella (chicken pox)		_____	_____	_____	_____	_____	_____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware. \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Name of family dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

<b>Screening Record</b> (For camp use only)	Screened by _____
Date screened _____ Time _____ am _____ pm	Updates/additions to health history noted <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None required
Meds received _____	
Current health needs identified _____	
Observational notes _____	