

Medical Information

The following pages **MUST** be completed and signed by a physician.

Acceptance to camp cannot be finalized until all medical forms are returned.

***Medical Provider - Please complete this form and send to Camp Capella directly,**

Email: info@campcapella.org

Camp CaPella PO Box 552 Holden, ME 04429. Please do not sign a form completed by camper, parent or guardian. Camp CaPella requires medical information from medical provider only.

Camper Name: _____

Disability/Diagnosis: _____

DOB: _____ Male: _____ Female: _____

Physician Name: _____

Address: _____

Phone Number: _____

Allergies (please list allergy and reaction)

Medication Allergies:

Food Allergies:

Other Allergies: (hay fever, animals, insect bites or stings, etc.)

Seizures

Is this camper subject to seizures? YES / NO *If yes, please attach seizure protocol.*

Seizure Type: _____ **Frequency:** _____

Seizure Triggers:

How long do seizures last? _____

Date of most recent: _____

Notify parent/guardian: ___ after every seizure ___ after seizure lasting ___ mins
___ no notice

Health History (Please check all that apply)

___ Heart Defect/Disease
Pox

___ Mononucleosis

___ Chicken

___ Diabetes
Ivy

___ Frequent Ear Infections

___ Poison

___ Measles

___ High Blood Pressure

___ Asthma

___ Hay Fever

___ Insect Stings

___ Mumps

___ Hospitalization

___ Lyme Disease

___ Other

Explain other:

Medical conditions requiring notification of guardian and physician:

Operations or serious injuries or mental health concerns:

Specialized Health Care Procedures

Does the camper require a specialized health care procedure while attending camp (i.e. nebulizer treatments, catheterization, etc.): YES NO If yes, please complete the following:

Name of Procedure: _____

Description of Procedure: Please include time intervals and conditions or symptoms that warrant repeating the procedure

List any precautions staff must be aware of before, during or after the procedure:

Please attach another sheet if need for additional procedures.

Mental Health Information

Is there a history of mental health issues? YES NO

Have there been any recent issues? YES NO If yes, date of occurrence: _____

Has there been any hospitalization, or stay at a mental health facility, due to mental health issues? YES NO If yes, date of occurrence: _____

If yes to any of the above, please explain more.

Note: Any admission to psychiatric facility, residential program, or documented psychiatric episodes will disqualify camper from attending Camp CaPella.

Female Camper Information

Has this camper menstruated? YES NO

If not, has she been informed? YES NO

If yes, does she require assistance? YES NO

Additional comments:

Immunizations (you may attach immunization record in place of form)

	Year of Basic Immunization	Year of Last Booster
DTap	_____	_____
Tetanus	_____	_____
Polio (IPV)	_____	_____
MMR	_____	_____
Pneumococcal (PCV)	_____	_____
Haemophilus Influenza (HIB)	_____	_____
Hepatitis B	_____	_____
Varicella (Chicken Pox)	_____	_____
Meningitis	_____	_____
COVID19 Vaccine	_____	_____
Other	_____	_____

Are there any immunization exemptions due to religious, medical or other reasons? Yes No If yes, please explain: _____

***I understand and accept the risks of my camper not being fully immunized. I understand if there is an outbreak, I will be required to pick up my camper from the camp program.**

Parent/Guardian Signature

Date

Assistive Devices

Eyes: Does camper wear glasses? YES NO

If yes, color of frame? _____

Ears: Does camper wear hearing aids? YES NO

If yes, what support is needed? _____

Orthotics: Does camper wear AFO or other braces? YES NO

If yes, what support is needed?

Other assistive devices used:

Health Care Recommendations From Physician

Blood Pressure _____ **Weight** _____ **Height** _____

In my opinion, this individual is capable of participating in camp activities except for the restrictions stated below. YES NO

Limitations or Restrictions:

Medical Concerns or Treatments to be monitored during camp:

Camp CaPella has a hot tub for campers to use during the camp session, In your medical opinion is it safe for this camper to utilize the hot tub this summer?

Yes No

If the camper is able to use the hot tub, are there any individual protocols we should be aware of during this activity related to medical diagnosis or medication use? _____

Date of Most Recent Physical: _____

Please note: If your next physical is after June 1st, please include the most recent physical with your application and send Camp CaPella the updated physical within 2 weeks of your camper arriving at camp.

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I certify that I have completed a physical of this person on the date listed above, which is within one year of the expected camp participation date. This person is in satisfactory condition to participate in an active summer camp program for and with people with disabilities. I am aware of all medications prescribed to this camper, as listed on the medication form, and see no contraindications.

Physician Signature

Date

Physician Name and Title (Printed)

Address

Phone

Camp CaPella has created a summer camp program for 2024 that adheres to CDC/State of Maine guidelines for both Youth Day Programs and Overnight Camps. We ask you to consider carefully as you complete the camper medical forms and specifically address three questions:

1. Is this camper's medical status appropriate for participation in a summer camp program? Yes _____ No _____ Medical Provider Initials _____

2. If yes, would this camper be able to participate in either a day camp program or overnight program? Would you have a preference for which program they would participate? Day _____ Overnight _____ Medical Provider Initials _____

3. Are there any particular precautions Camp CaPella should take to further assure this camper's safety while participating in the camp program?

Signature of Medical Provider

Date