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

Please note that Camp CaPella does NOT have a fax machine. Forms must be mailed or emailed.

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: _____ **Date of Last Physical**:_____

Allergies (please list allergy and reaction)

Medication Allergies:

_____

_____

Food Allergies:

_____

_____

_____

_____

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

_____
_____
_____

If your camper has an Epi Pen or inhaler that they will need while at camp, Please see page 11 for permissions form.*

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**	__**Mononucleosis**	__**Chicken Pox**
__**Diabetes**	__**Frequent Ear Infections**	__**Poison Ivy**
__**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 including reason for admission (i.e Med Change, Behavorial etc.)

_____

_____

_____

Note: Any admission to psychiatric facility, residential program, or documented psychiatric episodes will not automatically disqualify camper from attending Camp CaPella. Please provide detailed information regarding admission in order for us to adequately assess campers fit for camp. Please be aware that we may reach out regarding additional information as we review applications.

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**

Medication

Please note - camper must be on a stable medication regime, and not in the process of changing medication or altering the dose of current medication, for at least one month prior to attending camp.

Important Note: An accurate med list must be collected by the healthcare staff in order for campers to attend camp. Upon check in for overnight campers, medications and instructions must be provided to the check in nurse. Day Campers will be called to confirm medications that they need to take and instructions before their first day of camp.

___ **This camper takes no medications on a routine basis.**

___ **This camper takes medications as listed below. Attach additional sheets if needed.**

Name of Medication	Dosage	Time Given
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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?_____
_____
_____

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

*__Medical Provider - Please complete this form. Please do not sign a form completed by camper, parent or guardian. Camp CaPella requires medical information from medical provider only.__

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 2025 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**

*Please see page 10 for Standing Orders needing Physician Signatures
** Please see page 11 for Epi Pen and Inhaler Permission Forms

Standing Orders Form 2025

If no known allergies to the following, a nurse or healthcare staff may administer:

1) Epinephrine (1:2000) Auto Injector Jr 0.15 mg IM prn for anaphylactic reaction, weight less than 66 pounds
2) Epinephrine Auto Injector (1:1000) 0.3 mg IM prn for anaphylactic reaction, weight greater than 66 pounds
3) Diphenhydramine HCL tabs/liquid/elixir po, weight/age-based dose for suspected major allergic reaction (difficulty breathing, facial swelling, generalized puritis, rash/hives that quickly spread, nausea/vomiting, irritability)
4) Bismuth Subsalicylate 30 cc after confirmation of no fever for age 12 and up. As needed for heartburn, diarrhea and nausea
5) Glucose gel 15 grams po prn for hypoglycemia
6) Calamine Lotion topically prn for minor skin irritation/itching/rash
7) Triple antibiotic ointment topical prn for skin abrasion and minor cuts
8) Saline eye flush prn for eye irritation
9) Sunscreen lotion SPF 15-50, topically prn for sun exposure
10) Superficial Splinter Removal prn for foreign body, excluding facial area
11) Hydrocortisone cream 0.05%-1% topical for minor skin irritation/rash/itching
12) Hypoallergenic fragrance-free cream or lotion topically prn for minor skin irritation
13) Loperamide Hydrochloride and simethicone tabs, weight and age dosing for diarrhea and gas
14) Anti-itch spray per dosing instructions for itching
15) Acetaminophen tabs/liquid po, weight and age dosing prn for pain/fever
16) Ibuprofen tabs/liquid po weight and age dosing prn for pain/fever
17) Insect repellant as needed
18) Aloe Vera after sun as needed for minor redness
19) Throat lozenges as needed for minor sore throat/cough with follow up as needed
20) Basic First Aid Supplies and Bandages as needed

Campers Name:_____ **Date of Birth:**_____

Primary Healthcare Providers Signature:_____ **Date:**_____

Healthcare Provider Permission Form

APPROVAL FOR CARRYING AND SELF ADMINISTERING EMERGENCY MEDICATION

As the primary healthcare provider for (campers name)_____, I order the carrying and self-administering, as medically necessary of the following medications by the above named camper: (Circle all that apply or list other emergency self-medication device.)

a. Asthma Inhaler
b. Epinephrine Pen
c. Other:_____

Further, I confirm that this camper has the knowledge and the skills to carry and safely self-administer the indicated emergency medication while at camp.

_____ _____
Primary Healthcare Providers Signature Date

Parent Permission Form

USE OF SELF ADMINISTERED EMERGENCY MEDICATIONS

As the parent or guardian of (campers name) _____, I approve of the carrying and self administering, as medically necessary of the medications listed above by my child.

Further, I confirm that my child has the knowledge and the skills to safely carry and self-administer the above listed emergency medication at camp.

_____ _____
Parent or Guardian Signature Date