Health History and Physical Form

Form Rev. 250127

Camp Courageous
PO BOX 418
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www.campcourageous.org

Each camper attending Camp Courageous must have a physical exam performed by a licensed physician not more than 12 months prior to an accepted attendance date at Camp. This form is preferred but is not specifically required by Camp Courageous.

Subject First Name	MI	Subject Last Name
Birthdate yyyy/mm/dd	Age	Camp Date (If Known)

Gender: ☐ Female ☐ Male ☐ Other: _____ (Optional)

MEDICAL DIAGNOSES

Primary Medical Diagnosis:	Secondary Medical Diagnosis:
Mental Health Diagnoses:	

COMMUNICABLE DISEASES AND VACCINATION DATES

Polio:	DTP:	History of: ☐ Hep-B/C ☐ HIV ☐ TB ☐ MRSA ☐ HSV	
Tetanus:	MMR:	HBV:	

ALLERGIES - Please specify dietary, medical, and environmental allergies, and describe typical reactions. Attach a secondary sheet if needed.

☐ Carries Epi-Pen

ONGOING CARE & ACCOMODATIONS - Please indicate if this individual requires special care with any of the following

Surgical Procedures & Medical Treatments	Heart Conditions	Prosthesis
Respiratory Conditions	Bowel Routines	Urinary Routines
Skin Conditions	☐ G/J Tube ☐ Tracheostomy Tympanostomy: ☐ L ☐ R ☐ Ear Plugs Required	
	☐ Colostomy ☐ Urostomy ☐ Catheter ☐ Monitor BMs	

SEIZURES - Please complete this section if this individual exhibits any seizure conditions

Seizure Type/Protocol	Triggers or Activites	Occurrence: ☐ Day ☐ Night
Seizure Frequency	Oncoming Seizure indicators	
Last Seizure Occurrence	Notes or Recovery Guidelines	

VITALS AND REVIEW

T:	R:
P:	BP:
O2:	Ht:
	Wt:

Vision Exam Date:
Wears: ☐ Glasses ☐ Contacts
Hearing Aid: ☐ Left ☐ Right

Respiratory:	Gastrointestinal:
Circulatory:	Musculoskeletal:
Ear/Nose/Throat:	Reproductive:
Urinary:	Endocrine:
Nervous System:	Epidermal:

PLEASE LIST ALL MEDICATIONS THIS INDIVIDUAL WILL BE TAKING WHILE AT CAMP IN THE GRID PROVIDED ON THE BACK OF THIS FORM

PHYSICIAN SIGNATURE

I have thoroughly examined the individual specified herein and reviewed their health history. It is my professional opinion that they are medically stable and able to participate in camp activities within their personal limits.

Name of Medical Practice	Physician Name	
Street Address	Exam Date	Signature Date
Address 2	Physician Signature	
City, State, Zip		
Phone	Fax	

LIST OF MEDICATIONS

Use this space to list any medications this individual will need while staying at Camp Courageous. Please include medications that will need to be administered by a member of the nursing staff, and those which the individual will be using themselves.

Include all supplements and medications of all forms, both prescription and non-prescription.

To expedite arrival check-in at Camp Courageous:

1. Deliver medications to Camp Courageous ahead of the scheduled date.
2. Notify the nursing department of all changes in prescriptions as soon as possible - at least two weeks ahead of the check-in date.
3. Send only the number of doses your camper will need during their stay **plus one spare dose**
4. Package and label the medications with:
   - A. The prescribed individual's name
   - B. Name of the medication
   - C. Dosage of the medication
   - D. Frequency and times the medication is to be taken

Common Terminology

- BID = Two Times Daily
- TID = Three Times Daily
- QID = Four Times Daily
- PRN = As Needed
- GTT = Drop
- OU = Each Eye
- SUPP = Suppository
- BS = Blood Sugar
- RT = Right
- LT = Left
- 15ml = One Tablespoon
- 5ml = One Teaspoon
- Times:
  - 07 = 7 AM
  - 08 = 8 AM (breakfast)
  - 09 = 9 AM
  - 10 = 10 AM
  - 11 = 11 AM
  - 12 = 12PM (lunch)
  - 13 = 1 PM
  - 14 = 2 PM
  - 15 = 3 PM
  - 16 = 4 PM
  - 17 = 5 PM (dinner)
  - 18 = 6 PM
  - 19 = 7 PM
  - 20 = 8 PM
  - 21 = 9 PM
  - 22 = 10 PM
  - HS = Bedtime

MEDICATION NAME	DOSAGE	FREQUENCY	TIMES
Example: Dilantin chewable	50mg - 1 tablet	QID	08, 12, 17, hs
Example: NovoLog flex pen injection	12 units	TID, with food	08, 12, 17,

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