Seguin RCA Camp

Health information

Camper's name:____

SEX [ ] MALE [ ] FEMALE _______AGE ______ HEIGHT _______WEIGHT

Any health or medical changes from last year to this year? [ ]YES [ ]NO
If yes describe: ____
____
____

General health
[ ] No limitation in daily activities [ ] Few limitations [ ] Many limitations

MEDICATION/DEVICES
Any medication changes from last year to this year? [ ]YES [ ]NO
If yes describe: ____
____
____

Can camper administer own medication? [ ] Yes [ ] No
Needs verbal prompting [ ] Yes [ ] No Needs supervised guidance [ ] Yes [ ] No

Name	Dosage	Reason	Duration

IMPORTANT:
A physician's order for medications currently being taken by camper must accompany this application. Medication containers/dispensing devices must be marked with campers/ name/ dosage/ medication. It would be most helpful if medication can already be put into dispensing devices for the weekend.
(see attached physician's order form.)

Corrective devices or special equipment needed? [ ] Yes [ ] No
Can person manage these by him herself? [ ] Yes [ ] No
Please indicate [ ] glasses [ ] contact lenses [ ] hearing aid [ ] bridge [ ] dentures
[ ] cane [ ] walker
[ ] wheelchair -- motorized [ ] non motorized[ ]
[ ] other____

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ALLERGIES

The following questions are not meant to replace a physician's recommendations or diagnosis and is only meant to serve as a guideline so that the camp staff can respond to these issues.

THE FOLLOWING LIST ONLY SERVES AS A GUIDE.

IS THE CAMPER ALLERGIC TO ANY OF THE FOLLOWING?

[ ] INSECT STINGS	[ ] GLUTEN	[ ] PEANUTS	[ ] MILK
[ ] ANIMALS	[ ] SOY	[ ] CHOCOLATE	[ ] FISH
[ ] SHELLFISH	[ ] MOLD	[ ] FLOWERS	[ ] GRASS

Does the camper have seasonal allergies? [ ] YES [ ] NO

- **Does s/he take medication? [ ] YES [ ] NO**
- **What kind?____**

  ____

Does the camper suffer from asthma? [ ] YES [ ] NO

- **DOES S/HE TAKE MEDICATION? [ ] YES [ ] NO**
- **WHAT KIND? ____**

  ____

- **ARE THERE ANY TRIGGERS? [ ]YES [ ]NO**
- **LIST ALL____**

  ____

SEIZURES

Frequency of seizures (mark one)

[ ] None	[ ] controlled
[ ] monthly	[ ] less then monthly
[ ] more than weekly	[ ] weekly or less

[ ] estimated seizures ____________per day ______________per week

DESCRIBE SEIZURE AND TREATMENT TO BE DONE IN THE EVENT ONE OCCURS:

____

____

____

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Camper's name:____

MOBILITY
[ ] Independent [ ] Needs assistance
Describe: ____
____
____

COMMUNICATION
[ ] Reads
[ ] Writes
[ ] Finger Spells
[ ] Understands simple directions
[ ] Gestures
[ ] Communication Board
[ ] Understands most speech
[ ] Talks
What signs are used?____
____
____
What signs are understood? ____
____
____

VISION (Mark one)
[ ] Sees well (no glasses)
[ ] Vision problems (wears glasses)
[ ] Little or no useful vision (even with glasses)

HEARING (Mark one)
[ ] Hears normal voice
[ ] Hears only loud voices
[ ] Uses hearing aid
[ ] Little or no useful hearing

Please list other health concerns you would like staff to be aware of
____
____
____
____
____
____
____