Required Medical Paperwork *Instruction Page*

Four documents are required from a doctor's office. We highly encourage you to print off this packet and bring it with you to your camper's next medical appointment.
Note, physician signatures are mandatory on three of the medical documents.

1. Medical Form

The Medical Form must be completed within 12 months of attending their camp session.
A physician signature is required on this page.

2. Medication List

The Medication List must include detailed information regarding all prescribed *and* over the counter medications taken by the camper.
A physician signature is required on this page, regardless if the camper takes prescribed and/or over-the-counter medications or does not take any medications.

3. Medical Protocols

The Medical Protocol Form must include all behavior and medical protocols set in motion by a medical professional.
A physician signature is required on this page, regardless if the camper has special medical protocols or does not have any medical protocols.

4. Immunizations

A current record of immunizations is required. Tetanus must be current within 10 years.

Medical Form

Camper Name: _____ **Birthdate:** _____

****Attendance at Easterseals Camp is not allowed without a completed Medical Form or school/sports physical on file for a doctor's visit that has occurred within 12 months of your camp session. ****

Date of Office Visit: _____

Physical Examination / Health History

Height (ft/in): _____

Weight (lbs): _____

1. List any chronic health problems (e.g. asthma, pressure sores, cough, constipation) of which the camp staff should be aware:

2. Are the camper's immunizations up-to-date and complete, including Tetanus? ☐ Yes ☐ No

3. Does the camper currently have any chronic or acute infection? ☐ Yes ☐ No
   If yes, please explain:

4. Does the camper have any known allergies? ☐ Yes ☐ No
   If yes, please describe:

5. Does the camper have seizures? ☐ Yes ☐ No
   If yes, describe what type:

   Seizure in the past year? ☐ Yes ☐ No

6. How would you assess the camper's current health? ☐ Good ☐ Fair ☐ Poor

Dietary

1. Please list any dietary restrictions:

2. Is the camper on a modified texture diet? ☐ Yes ☐ No

   If yes, to what consistency based on the Dysphagia Guidelines? ☐ Level 1 ☐ Level 2 ☐ Level 3

3. Is the camper formula fed or on a tube feeding? ☐ Yes ☐ No

   Route: ☐ Orally ☐ GT ☐ JT If GT/JT, type: ☐ Pump ☐ Gravity

   Name of formula: _____

   Rate/Dose: _____ Frequency: _____

   Special Instructions: _____

Restrictions

1. Has the camper been hospitalized or treated in an emergency room recently? ☐ Yes ☐ No

   If yes, please explain:

2. Are there any physical conditions, past operations, or injuries that should restrict camp activity?

   ☐ Yes ☐ No

   If yes, please explain:

This patient **<u>is able</u>** to participate in the Easterseals Nebraska Summer Camp and Respite Program.
Note, <u>three</u> signatures are required throughout this packet.

Physician Signature: _____ **Date**: _____

Physician's Name (Please Print): _____ *Signature 1 of 3*

Office Phone: _____ Emergency Phone: _____

Address: _____ City/State: _____ Zip: _____

Medication List

Camper Name: _____ **Birthdate:** _____

The following medications are available in the Camp Health Office and will be administered at the discretion of a Registered Nurse, if approval is indicated by the camper's physician.

1. Please indicate "Yes" or "No" for approval and add any significant notes.

Drug Name	Route	Doctor's Orders *Check One*		Notes
Ibuprofen	PO - tablet	☐ Yes	☐ No	
Acetaminophen	PO - tablet	☐ Yes	☐ No	
Midol	PO - tablet	☐ Yes	☐ No	
Pepto-Bismol	PO - elixir	☐ Yes	☐ No	
Diphenhydramine (Benadryl)	PO - tablet	☐ Yes	☐ No	
Fexofenadine Hydrochloride (Allegra)	PO - tablet	☐ Yes	☐ No	
Tums	PO - chewable tablet	☐ Yes	☐ No	
Loperamide Hydrochloride (Imodium)	PO - tablet/elixir	☐ Yes	☐ No	
Milk of Magnesia	PO - elixir	☐ Yes	☐ No	
Polyethylene Glycol (Miralax)	PO - elixir	☐ Yes	☐ No	
Anti-Itch Cream (Hydrocortisone)	Topical Cream	☐ Yes	☐ No	
Neosporin Ointment	Topical Cream	☐ Yes	☐ No	
Aquaphor	Topical Cream	☐ Yes	☐ No	
Unmethylated Throat Lozenges	PO - lozenge	☐ Yes	☐ No	
Diaper Rash Cream w/ Zinc Oxide	Topical Cream	☐ Yes	☐ No	
Tetrahydrozoline (Vizine)	Eye drop	☐ Yes	☐ No	

Dosage & schedule will be per label by age/weight unless specified.

2. Please list/attach all prescribed medications and any additional over-the-counter medications.

☐ Check this box if the camper DOES NOT take any prescription medications.

☐ Check this box if medications are attached on a separate sheet.

Medication: _____ Dosage: _____ Reason: _____
How often/frequency: _____ Special Instructions: _____

Medication: _____ Dosage: _____ Reason: _____
How often/frequency: _____ Special Instructions: _____

Physician Signature: _____ **Date**: _____

Physician's Name (Please Print): _____ *Signature 2 of 3*

Medical Protocols

Camper Name: _____ **Birthdate:** _____

Please list all medical protocols specific to the above camper.

This may include, but not limited to:

- **Allergy, asthma, and seizure action plans**
- **Protocol of when to administer PRN psychotropic medications**

☐ Check this box if the camper DOES NOT have any specific medical protocols.

☐ Check this box if medical protocols are attached on a separate sheet.

_____

_____

_____

_____

_____

_____

_____

_____

Physician Signature: _____ **Date**: _____

Physician's Name (Please Print): _____ *Signature 3 of 3*

Completed forms may be sent to:

Easterseals Nebraska
Attn: Holly Windorski
12565 W. Center Rd, Suite 100
Omaha, NE 68144
Phone: (402) 930-4106 / Fax: (888) 611-6396

Immunization records must also be attached.