CAMPER MEDICAL INFORMATION/EMERGENCY ROOM FORM

SITE:_____ Today's Date: _____

NAME:_____ DOB:_____

ALLERGIES *(MEDICATION):*_____

ALLERGIES (*food):*_____ ALLERGIES *(environmental):*_____

LAST TETANUS SHOT:_____ SEX: ___Male ___Female

SPECIFIC MEDICAL/BEHAVIORAL CONDITION(S):

- ***Place an "X" next to applicable areas***
- ***Documentation must be** written **in the "COMMENTS" section below for areas marked "X" that have an asterisk (*) next to them.***
- ***If you need additional space for comments, please use another sheet of paper and place a large "X" in this box:*** ☐

___DIETARY RESTRICTIONS* ___PHYSICAL LIMITATIONS* ___ENCOPRETIC ___ENURETIC

___NIGHTIME WAKENING**** (MD order and consent to be attached***

____SEIZURE DISORDER* ***(seizure protocol to be attached if applicable)***

___ASTHMA* ***(asthma action plan to be attached if applicable)***

___HEARING DEFICIT ___WEARS GLASSES ___MENSTRUATING

___OTHER:_____

COMMENTS (Please note any pre-existing condition as well as instructions if family requires notification within a specific timeframe regarding medical treatment):__________

Place an "X" for the times this med. is given:

MEDICATION	DOSE	8 A	12 P	3 P	8 P	PRN (hrs)	REASON

Place an asterisk to the left of the medication name if that medication needs refrigeration.