SPIRIT CAMP GENERAL MEDICAL EVALUATION

(To be completed by family physician)

Camper's Name: _____

Diagnosis: _____

Date of Last Exam: _____

Height: _____ Weight: _____

Does individual have a history of seizures: ❑ Yes ❑ No

Date of last seizure: _____ Type: _____ Frequency: _____

Presently controlled: ❑ Yes ❑ No

Recent surgeries – (dates): _____

_____

_____

Is individual restricted from: ❑ Swimming ❑ Other

_____

Special concerns/limitations: _____

Are immunizations up to date: ❑ Yes ❑ No

Need a copy of your child's immunizations from your family physician.

Date of last tetanus: _____

This should be administered if not up to date - kindergarten and every five years after that.

Does your child have any other medical or mental health concerns: _____

_____

_____

_____

Physician (Printed)

_____ _____

Physician's Signature Date

Medication during camp: Medications are dispensed at each meal and at bedtime. We would prefer to give as many evening medications as possible with supper. If the evening medications must be given at bedtime, please indicate this below.

Name of Medication	**Route** *(Mouth, IV, SQ, etc.)*	**Dosages**	**Frequency** *(include even/odd days)*	**Circle the time of day to be given**
				AM NOON PM BED
				AM NOON PM BED
				AM NOON PM BED
				AM NOON PM BED
				AM NOON PM BED
				AM NOON PM BED
				AM NOON PM BED
				AM NOON PM BED
				AM NOON PM BED
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