

CampAbility Medical Information

Personal Information

Child's Name:		Date of Birth MM/DD/YYYY
Parent's Name:		Home Phone Number:
Address:		Other Contact Numbers ie. Cell or Work
Height:	Weight:	

Emergency Information

Emergency Contact / Relationship:	Phone Number:
Emergency Contact / Relationship:	Phone Number:
Physician's Name:	Phone Number:
Specialist's Name / Relationship:	Phone Number:

Medical / Health Information

Diagnosis:	Other Health Considerations:
Medical Orders / Protocols <input type="checkbox"/> Describe & Attach Copy:	
Visual Difficulties <input type="checkbox"/> Describe:	Auditory Difficulties <input type="checkbox"/> Describe:
Respiratory Problems <input type="checkbox"/> Describe:	Gastro-intestinal Difficulties <input type="checkbox"/> Describe:
Seizure Activity <input type="checkbox"/> Describe:	Heart Condition <input type="checkbox"/> Describe:

CampAbility Medical Information

Medical / Health Information Continued

Mobility Problems <input type="checkbox"/> Describe:	Mobility Aids <input type="checkbox"/> Describe:
Fine Motor Restrictions <input type="checkbox"/> Describe:	Gross Motor Restrictions <input type="checkbox"/> Describe:
Dietary Restrictions <input type="checkbox"/> Describe:	Allergies / Sensitivities <input type="checkbox"/> Describe:

Medication	Dosage	Administration	Possible Side Effects

Special Considerations

Support Services <input type="checkbox"/> Describe, eg., nursing care, physiotherapy:
Specialized Equipment <input type="checkbox"/> Describe, eg., scooter board:
Other Considerations <input type="checkbox"/> Describe:

Parents Signature

Date