

Requires both Doctor AND Guardian's Signature. **Return the ORIGINAL with camp application – DO NOT FAX.**

Information on this form is gathered to assist in identifying appropriate care.

Call Camp New Hope's office at 217-895-2341 if you have questions about this form.

Camper Applicant Name: _____ Birthdate: _____ Age: _____ Sex: M or F

Contact Person: _____ Best Phone: _____

Address: _____ Alt Phone: _____

Health History *Check applicable history*
**** Must explain on back of form**

- Frequent Ear Infections
- Heart disease/defect **
- Seizure Disorder
- Diabetes
- Bleeding/Clotting Disorders **
- HTN (High Blood Pressure)
- MRSA/VRE or Drug-resist infection **
- Measles/Mumps/Chicken Pox
- Axonal/Cervical Instability
- Heat Sensitivity

Allergies: (Please list) _____

DME/Other:

- Foley Catheter
- G-tube/J-tube
- CPAP/Bi-Pap/Apnea monitor
- Other --

Immunizations up to date? Yes or No. If No, explain _____

Current Diagnosis: _____

Pertinent History: _____

Diet: (Please circle one of the following) Regular, Diabetic/NCS/LCS, Gluten Free, No Added Salt

Alteration: (Please circle all that apply) Pureed, Mechanical Soft, Mechanical soft meat only, Honey-thick, Nectar-thick, Pudding-thick

Food Restrictions: _____

Does the camper have seizures? ___ Yes ___ No

What type? _____ Frequency _____

Any special treatments in addition to basic airway protection and safety precautions? Explain _____

Any other special restrictions or considerations should be written here: _____

Medication	Dose	Time	Medication	Dose	Time	Medication	Dose	Time

Parent/Guardian:

This health history is accurate, to the best of my knowledge, and the person herein described has permission to engage in all camp activities (unless otherwise noted). I grant permission for camp personnel to administer medications as directed.

Signature of Parent/Guardian _____ Date _____

Medical Provider Statement:

I have examined the above camper applicant within the past year on _____ (date of exam).

To my knowledge, the above named applicant has no conditions, including infectious diseases, which precludes his/her participation in an active camp program (unless otherwise noted) and his/her immunizations are up to date. Medications may be administered as stated by the guardian/parent/supervisor at check-in.

Licensed Provider Signature _____ Printed Name: _____

Address: _____ Phone: _____

Date form completed: _____ by Parent/guardian/supervisor, Physician, APN/ PA, RN/LPN