Child Diagnosed Medical Form & Physician Statement

Our volunteer medical staff supervises the health and well-being of campers and volunteers. Please complete **all** requested information in the following sections. Please include any additional health concerns not specifically requested in the spaces provided. To the extent any information is designated as protected health information under the Health Insurance Portability and Accountability Act (HIPAA), SRNA agrees to abide by all applicable laws. The health history and medications must be reviewed by the child's treating physician or healthcare professional (e.g., PA or NP), and the accompanying Physician Statement must be completed and signed.

Name of your child's family physician/pediatrician: _____ Phone #: _____
Name of your child's neurologist/specialist: _____ Phone #:_____

MEDICAL INSURANCE COVERAGE
Insurance Carrier:_____ Policy Holder's Name:_____
Policy #:_____ Group #:_____

Please submit a copy of the front and back of the insurance card along with this form.

Health History

Does your child have any known MEDICATION ALLERGIES? (CHOOSE ONE) ☐YES ☐NO If yes, please explain: _____

Does your child have any known FOOD ALLERGIES? (CHOOSE ONE) ☐YES ☐NO If yes, please explain: _____

Does your child have any known additional ALLERGIES (e.g., sun, latex, plants, etc.)? (CHOOSE ONE) ☐YES ☐NO
If yes, please explain: _____

Does your child use any adaptive devices? ☐Manual wheelchair ☐Power chair ☐Walker ☐Crutches ☐Orthotics/Braces ☐Other
If "Other" is chosen, please explain:_____

In the box below: Mark NOW if your child currently has, PAST if they did have, or leave blank if never had.

☐Now ☐Past	ADD/ADHD	☐Now ☐Past	Cognitive Delay	☐Now ☐Past	Frequent Colds	☐Now ☐Past	Kidney Disease	☐Now ☐Past	Swimmer's Ear
☐Now ☐Past	Anxiety/Depression	☐Now ☐Past	Constipation	☐Now ☐Past	Hay fever	☐Now ☐Past	Panic Attacks	☐Now ☐Past	Urinary Tract Infection
☐Now ☐Past	Asthma	☐Now ☐Past	Diabetes	☐Now ☐Past	Headaches	☐Now ☐Past	Peanut/Nut Allergy*	☐Now ☐Past	Wheezing
☐Now ☐Past	Back/Neck Pain	☐Now ☐Past	Diarrhea	☐Now ☐Past	Heart Conditions	☐Now ☐Past	Pet Allergy*	☐Now ☐Past	Seizures
☐Now ☐Past	Bee Sting Reactions*	☐Now ☐Past	Ear Infection	☐Now ☐Past	Hepatitis/Hepatitis Exposure	☐Now ☐Past	Pneumonia	☐Now ☐Past	
☐Now ☐Past	Bladder Control Problems	☐Now ☐Past	Eating Disorder	☐Now ☐Past	Homesickness	☐Now ☐Past	Scoliosis	☐Now ☐Past	
☐Now ☐Past	Bleeding/Clotting Disorders	☐Now ☐Past	Emotional Problems/Self Injurious Behavior	☐Now ☐Past	Hypertension/High Blood Pressure	☐Now ☐Past	Severe Menstrual Cramps	☐Now ☐Past	
☐Now ☐Past	Cerebral Palsy	☐Now ☐Past	Fainting Spells	☐Now ☐Past	Indigestion	☐Now ☐Past	Sinusitis	☐Now ☐Past	

* If you indicated any allergies above, do your allergies require an EpiPen to relieve symptoms? (CHOOSE ONE) ☐YES** ☐NO
**If yes, you must bring an EpiPen with you to camp.
If you answered "NOW" to any of the above questions, please explain in detail: _____

Is there any other physical, medical, or emotional information that the medical staff should be aware of (e.g., special diet, pregnancy, motion sickness, recent surgeries, serious injuries, depression, suicide threats or attempts, eating disorders, anxiety disorders, etc.)?

_____

_____

Are upcoming surgeries or new medical equipment on order that your child will receive before camp? If yes, list the nature of surgery, proposed date and/or new medical equipment (if applicable).

_____

Are there any activity restrictions for your child while participating at camp? If yes, please explain._____

_____

Has your child been exposed to a communicable disease (e.g., head lice, strep throat, mononucleosis, etc.) in the last six (6) months?
(CHOOSE ONE) ☐YES ☐NO If yes, please describe:_____

_____

IMPORTANT: YOU ARE REQUIRED TO NOTIFY THE SRNA CAMP DIRECTOR IF YOUR CHILD HAS BEEN EXPOSED TO A COMMUNIABLE DISEASE AFTER SUBMISSION OF THIS APPLICATION.

Does your child require any respiratory equipment (e.g., Bi-Pap, C-Pap, Cough Assist, Inhaler, etc.)?(CHOOSE ONE) ☐YES ☐NO
If yes, please detail each piece of equipment and when it should be used: _____

_____

Does your child wear glasses, contacts, hearing aid, retainer, helmet, etc.? (CHOOSE ONE) ☐YES ☐NO
If yes, please describe each piece of equipment and when it should be used: _____

_____

MEDICATIONS

ALL prescription medications are the responsibility of the parent/guardian of the child during the camp week. Do not share medications, including non-prescription medications (such as allergy pills, cold tablets, vitamins, etc., with anyone outside of your own family/children in your custody while on camp. All medications should be secured in your personal belongings or a locked vehicle. Medications requiring storage or you prefer them to be locked outside of shared family space, you may turn them into the medical staff upon arrival at camp to be stored in the locked medical facility. **PLEASE BRING ENOUGH MEDICATION FOR THE FULL CAMP STAY PLUS 2 ADDITIONAL DAYS. ALL PRESCRIPTION MEDICATIONS MUST BE BROUGHT TO CAMP IN THE ORIGINAL CONTAINER(S) WITH ORIGINAL PHARMACY LABEL(S) OR ASK YOUR PHARMACIST FOR AN EXTRA, FULLY LABELED CONTAINER FOR USE AT CAMP.**

I hereby give permission for the camp medical staff to administer my child/family member the following (or similar brand of) over-the-counter medication deemed necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise. Check all that apply:

☐Headache----------Acetaminophen or Ibuprofen
☐Upset Stomach----------Pepto Bismol
☐Poison Ivy----------Hydrocortisone cream
☐Allergy/Congestion/Cold------Benadryl/Sudafed
☐Diarrhea----------Imodium AD
☐Menstrual Cramps---------Ibuprofen
☐Constipation----------Dulcolax/Fleet Enema/MiraLax

_____ _____

Signature of Parent/Legal Guardian Date Signature of Parent /Legal Guardian Date

Please complete the listing below with all medications, including non-prescription or over-the-counter medications such as dietary supplements your child is taking and the schedule by which they are given. (Attach a separate sheet detailing all other medications if additional writing space is required.

Medication	Strength of each pill (MG)	Times and how medication is given? (e.g. at meals, crushed in food, etc.)	Purpose of medication?

SRNA Annual QOL Family Camp 2024: Physician Statement

This section is to be completed by your child's neurologist or primary medical professional (e.g., pediatrician, PA, NP, physiatrist, etc.) who is familiar with your child's diagnosis. This professional should be best able to determine if your child is eligible to attend SRNA Family Camp. This evaluation must take place no more than twelve months prior to the start of the camp session.

Camper's Name:_____ Age: _____

Vital Signs: Height:_____ Weight: _____ Pulse:_____

Resp. Rate (resting):_____ Blood Pressure (Resting, Sitting): _____

General Inspection:_____

	Status, Essential Findings, Deviating from Normal
Head	
Eyes/Vision	
Nose	
Mouth/Teeth	
Ears/Hearing	
Neck/Thyroid	
Thorax/Lungs	
Heart	
Abdomen/Hernia	
Skin	
Lymphatics	
Spine	
Extremities	
Emotional Status	

Recommendations and/or Restrictions while at camp:

Swimming: _____

Adaptive Sports: _____

Diet:_____

Strenuous Activity:_____

Other:_____

Note to Health Provider:

1. Participation involves group living and activities in an outdoor setting, a high level of physical activity, adaptive sports and swimming**. In your medical opinion, is the SRNA QOL Family Camp an appropriate environment for this child?**
   (CHOOSE ONE) ☐**YES** ☐**NO**
2. **Is it your opinion that this child is medically and emotionally able to engage in camp activities (e.g. daily physical activity and adaptive sports), except as noted above?**
   (CHOOSE ONE) ☐**YES** ☐**NO**

_____ Print Physician/Medical Professional's Name

_____ Physician/Medical Professional's Signature

_____ Date

_____ Address

_____ City

_____ Phone Number

PLEASE UPLOAD THIS COMPLETED AND SIGNED FORM TO YOUR ONLINE FAMILY APPLICATION LINK AFTER COMPLETION.