CAMP AMERIKIDS®

A program of The ELM Project

This packet is to be filled out by health care provider

Camper Medical Application 2024

88 Hamilton Avenue • Stamford, CT 06902
Phone (203) 658-9577 • Fax (203) 658-9615

Today's Date: _____ Session Date: **Sunday, August 18th – Saturday, August 24th**

Child's Name: _____ Age: _____ Date of Birth: _____

Sex: Male ❑ Female ❑ Other ❑ If other, please describe: _____

*****Copy of Insurance Card MUST BE ATTACHED*****

UNDERLYING MEDICAL CONDITION(S):

Primary Diagnosis: _____ Any secondary diagnosis: _____

If HIV+, how was the child infected? Mother to child: _____ Other: _____

Is the child aware of their diagnosis: Yes ❑ No ❑

If yes, how long have they known? _____

Has the child had any AIDS defining illnesses / Opportunistic Infections: Yes ❑ No ❑

Diagnosis: _____ Date: _____

Has child been hospitalized in the past year? Yes ❑ No ❑

If yes, why? (Include psychiatric): _____

_____

BEHAVIORAL OR MENTAL HEALTH HISTORY (INCLUDING ADHD, AUTISM SPECTRUM DISORDER, ETC):

_____

_____

PAST SURGICAL HISTORY: _____

_____

ALLERGIES: Food Allergies: _____ Medication Allergies: _____

Seasonal Allergies: Yes ❑ No ❑ Other: _____

Special nutritional requirements: _____

Restricted Activities: _____

IMMUNIZATIONS: Please attach copy of up-to-date immunization records (including COVID vaccination)

****IF WE DO NOT RECEIVE IMMUNIZATION RECORDS, CHILD MAY NOT ATTEND CAMP***

MEDICAL EQUIPMENT:

Does the child use any special medical equipment (i.e.: Feeding Tube, Home Oxygen, PICC line, etc.)?

If yes, please describe: _____

_____

Any additional comments:

_____

_____

PHYSICAL EXAM (May attach a recent H&P in lieu of completing the following section)

Most recent vitals: BP: _____ HR: _____ RR: _____ O2 Sat _____

Please check box if exam was normal on the following:

❑ Psychosocial development	❑ Behavioral	❑ HEENT	❑ Neck
❑ Dental	❑ Lung	❑ CVS	❑ Abdomen
❑ Extremities/MSK.	❑ Skin	❑ Neurological	❑ Back/spine

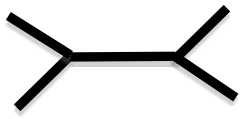
❑ Any abnormal findings: _____

Other pertinent physical exam findings:

_____

_____

Most recent CBC:
Date: _____



CD4 count: _____ Date: _____

Viral Load: _____ Date: _____

HEALTH CARE PROVIDER INFORMATION

I have examined _____ and find them to be physically able to attend Camp AmeriKids. I understand the attached medical regimen will be followed while the child is at camp (unless otherwise indicated on a "late changes" form).

Signature: _____ Date: _____

Name (print): _____

Address: _____

Phone number: _____ Office: _____

Beeper: _____ Emergency: _____

Health Care Provider stamp:

To be filled out by child's health care provider

MEDICATION LIST

(Including prescription and over the counter medications)

IMPORTANT: Please verify that the camper has an adequate supply of all prescribed medications, including opioids, for the entire camp duration. Campers lacking an adequate supply of medications will not be allowed to attend camp, no exceptions.

Child's Name: _____ **DOB:** _____

Prescription and over the counter medications to be given at Camp:

None Required ❑

Drug Name	Route	Dosage and Schedule	Indications	Comments

Additional Instructions: (As deemed necessary by health care provider to be implemented by RN)

_____

_____

After hours contact number in case of emergency: _____

Health Care Provider's Name: _____

Phone #:_____

Address: _____

License #: _____

Signature: _____ Date: _____