Camp Flame Catcher
Epilepsy Foundation of Greater Cincinnati and Columbus
895 Central Avenue, Suite 550
Cincinnati, OH 45202

MASTER MEDICAL FORM

****CONFIDENTIAL****

Please be aware that the information requested from your physician by this Master Medical Form is to be used solely in our efforts to provide as safe and healthy of an environment as we reasonably can. Neither the absence nor the nature of any response given on this form will determine your acceptance into the program. We are not seeking the disclosure of any information of which the confidentiality is protected by law except in accordance with that law.

Applicant's Information:

Name: ____ Age: ________

Birthdate: ____________________ Sex: ____

Address: ____ Phone: ____________________

City: ____ State: _________ Zip: ___________

Parent/Guardian names:____

E-mail address: ____

To be completed by physician:

Primary Physician (please print):____

Phone: ___________________________________

Neurologist (please print):____

Phone: __________________________________

Diagnosis: ____

Seizure Information:

Type(s):____

Frequency: ____

Patterns: ____

Warnings: ____

Height: ___________ Weight: ___________ Normal blood pressure: ___________

Normal temperature: _____________

Vagus Nerve Stimulator? _______ yes _______ no

Prescribed Diastat? _______ yes _______ no Last time used: _________________________

Typically use after: ____

Past Medical History

	Yes	No	If Yes, Describe
Auditory Impairment	_____	_____	_________________________________
Learning Disability	_____	_____	_________________________________
Mental Impairment	_____	_____	_________________________________
Psychological Impairment	_____	_____	_________________________________
Speech Impairment	_____	_____	_________________________________
Visual Impairment	_____	_____	_________________________________
Cardiac Problems	_____	_____	_________________________________
Diabetes	_____	_____	type: ___________________________
<u>Circulatory Problems</u>	_____	_____	_________________________________
PVD	_____	_____	_________________________________
Postural Hypotension	_____	_____	_________________________________
Hemophilia	_____	_____	_________________________________
<u>Pulmonary</u>	_____	_____	_________________________________

Asthma/COPD	_____	_____	______________________________
<u>Neurological Impairment</u>	_____	_____	______________________________
Hydrocephalus	_____	_____	______________________________
Has Shunt	_____	_____	______________________________
Sensory Loss	_____	_____	______________________________
Pain	_____	_____	______________________________
<u>Muscular Impairment</u>	_____	_____	______________________________
Contractures	_____	_____	______________________________
Weakness	_____	_____	______________________________
Degenerative Disc Disease	_____	_____	______________________________
<u>Skeletal Impairment</u>	_____	_____	______________________________
Spinal Column Injury	_____	_____	______________________________
Subluxing Joints	_____	_____	______________________________
Dislocating Joints	_____	_____	______________________________
Laminectomy/Fusion	_____	_____	______________________________
Scoliosis	_____	_____	degree/type: ___________________
Brace?	_____	_____	last x-ray:______________________
Kyphosis/Lordosis	_____	_____	degree/type: ___________________
Spondylolisthesis	_____	_____	______________________________
Spinal Abnormality	_____	_____	______________________________
Osteoporosis	_____	_____	______________________________
Heterotrophic Ossification	_____	_____	______________________________
Joint Disease	_____	_____	______________________________
Cranial Defects	_____	_____	______________________________
Fractures	_____	_____	location: ______________________
Healed?	_____	_____	______________________________

Immunizations/dates: (Line indicates number of shots in series)

DPT Series: ________________ ________________ ________________ ________________

Polio Series: ________________ ________________ ________________ _________________

Hib: ________________ ________________ ________________ ________________

MMR: ________________ ________________

HepB: ________________ ________________ ________________

Varicella: ________________

Pneumococcal: ________________

Meningococcal: ________________

Other: ____

Comments:

____

____

Screenings:

(1) T.B. Skin Test or X-ray: Date _______________ Negative ___ Positive ___

(2) Hepatitis B: HBsAG: Date _______________ Negative ___ Positive ___

Antibody to Hepatitis B: Yes ____ No ____

(3) Sickle Cell: Date _______________ Negative ___ Positive ___

(4) H.I.V.: Date _______________ Negative ___ Positive ___

(5) Other Screenings/Information: ____

Has applicant been exposed to any communicable diseases in the last six months? __________

Name of disease & date: ____

Is applicant now free from apparent communicable disease? ________________________________

Any recurring diseases (e.g., Malaria) ____

Other Disabilities or Chronic Illnesses ____

Allergies**

Food Allergies: ____

Medication Allergies: ____

Environmental Allergies: ____

What is the treatment if applicant is exposed to allergen? ________________________________

**Any special precaution or treatments? ____

Current Medication and/or Food Supplement Schedule

MEDICATION OR FOOD SUPPLEMENT:	PURPOSE:	DOSAGE:	FREQUENCY:

Mobility Status:

1. Ambulation: Independent ____ Dependent ____

   Walker ____ Cane ____ Crutches ____

Transfer Ability ____

Gait Pattern ____

2. Wheelchair: No _____ Electric _____ Manual _____

3. Orthotics: No ____ Yes ____ Describe: ______________________________________

4. Splints: No ____ Yes ____ Describe: _________________________________

5. Prosthetics: No ____ Yes ____ Describe: ___________________________________

Recommendations concerning restriction of activity: (List and Explain)

____
____
____

Are there any injuries, past illnesses, recent surgeries or recurring medical problems that the Camp Dream Catcher staff should be aware of?

____
____
____

Physician approval to participate in Aquatics: Yes ____ No ____

Additional Comments:

____
____
____

Date of last complete Physical Exam: ____

Physician's Signature ____ Date: ________________

Physician's Address ____

Phone: _________________________________

Please return form as soon as possible to: Epilepsy Foundation of Greater Cincinnati and Columbus
Camp Flame Catcher
895 Central Avenue, Suite 550
Cincinnati, OH 45202

***Medical information is accepted for a two (2) year period for participants 6 years and older. It is the responsibility of the parent/guardian to inform the Epilepsy Foundation of Greater Cincinnati and Columbus of any change in status.

Faxed Master Medical Forms <u>Are Not Acceptable-</u> Signatures Must Be Original (No Copies)

Thank You for Your Time