Camp Flame Catcher/ Camp for Champs
Epilepsy Alliance Ohio
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: _____

Or

Neurologist (please print):_____

Phone: _____

Height: _____ Weight: _____ Normal blood pressure: _____

Normal temperature: _____

Diagnosis: _____

Seizure Information:

Type(s):_____

Frequency: _____

Patterns: _____

Warnings: _____

Vagus Nerve Stimulator? _____ yes _____ no

Prescribed Emergency Medication _____ yes _____ no

Type: _____Last time used: _____

Use emergency medication after what period of time or circumstance:

_____

Past Medical History

	Yes	No	If Yes, Describe
Auditory Impairment	____	____	_____
Learning Disability	____	____	_____
Mental Impairment	____	____	_____
Psychological Impairment	____	____	_____
Speech Impairment	____	____	_____
Visual Impairment	____	____	_____
Cardiac Problems	____	____	_____
Diabetes	____	____	type: _____
Circulatory Problems	____	____	_____
PVD	____	____	_____
Postural Hypotension	____	____	_____
Hemophilia	____	____	_____
Pulmonary	____	____	_____
Asthma/COPD	____	____	_____

Neurological Impairment	____	____	_____
Hydrocephalus	____	____	_____
Has Shunt	____	____	_____
Sensory Loss	____	____	_____
Pain	____	____	_____
Muscular Impairment	____	____	_____
Contractures	____	____	_____
Weakness	____	____	_____
Degenerative Disc Disease	____	____	_____
Skeletal Impairment	____	____	_____
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	____	____	_____

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/ Camp for Champs staff should be aware of?

_____
_____
_____

Physician approval to participate in Aquatics: Yes ____ No ____

Physician approval to participate in horseback riding: 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 Alliance Ohio
Camp Flame Catcher/ Camp for Champs
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 Alliance Ohio of any change in status.

Thank You for Your Time