# Health History and Physical Form

Form Rev. 240119

**Camp Courageous**
**PO BOX 418**
**12007 190th Street**
**Monticello, IA 52310-0418**
**Phone: 319-465-5916**
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www.campcourageous.org

Each camper attending Camp Courageous must have a physical exam performed by a licensed physician not more than 12 months prior to an accepted attendance date at Camp. This form is preferred but is not specifically required by Camp Courageous.

| Subject First Name | MI | Subject Last Name |
|---|---|---|
| Birthdate yyyy/mm/dd | Age | Camp Date (If Known) |

Gender: ☐ Female ☐ Male ☐ Other: _____ (Optional)

**MEDICAL DIAGNOSES**

| Primary Medical Diagnosis: | Secondary Medical Diagnosis: |
|---|---|
| Mental Health Diagnoses: | |

**COMMUNICABLE DISEASES AND VACCINATION DATES**

| Polio: | DTP: | History of: ☐ Hep-B/C ☐ HIV ☐ TB ☐ MRSA ☐ HSV | |
|---|---|---|---|
| Tetanus: | MMR: | HBV: | |

**ALLERGIES -** Please specify dietary, medical, and environmental allergies, and describe typical reactions. Attach a secondary sheet if needed.

☐ Carries Epi-Pen

**ONGOING CARE & ACCOMODATIONS** - Please indicate if this individual requires special care with any of the following

| Surgical Procedures & Medical Treatments | Heart Conditions | Prosthesis |
|---|---|---|
| Respiratory Conditions | Bowel Routines | Urinary Routines |
| Skin Conditions | ☐ G/J Tube ☐ Tracheostomy Tympanostomy: ☐ L ☐ R ☐ Ear Plugs Required | |
| | ☐ Colostomy ☐ Urostomy ☐ Catheter ☐ Monitor BMs | |

**SEIZURES** - Please complete this section if this individual exhibits any seizure conditions

| Seizure Type/Protocol | Triggers or Activites | Occurrence: ☐ Day ☐ Night |
|---|---|---|
| Seizure Frequency | Oncoming Seizure indicators | |
| Last Seizure Occurrence | Notes or Recovery Guidelines | |

**VITALS AND REVIEW**

| T: | R: |
|---|---|
| P: | BP: |
| O2: | Ht: |
| | Wt: |

| Vision Exam Date: |
|---|
| Wears: ☐ Glasses ☐ Contacts |
| Hearing Aid: ☐ Left ☐ Right |

| Respiratory: | Gastrointestinal: |
|---|---|
| Circulatory: | Musculoskeletal: |
| Ear/Nose/Throat: | Reproductive: |
| Urinary: | Endocrine: |
| Nervous System: | Epidermal: |

**PLEASE LIST ALL MEDICATIONS THIS INDIVIDUAL WILL BE TAKING WHILE AT CAMP IN THE GRID PROVIDED ON THE BACK OF THIS FORM**

**PHYSICIAN SIGNATURE**

I have thurougly examined the individual specified herein and reviewed their health history. It is my professional opinion that they are medically stable and able to participate in camp activites within their personal limits.

| Name of Medical Practice | Physician Name | |
|---|---|---|
| Street Address | Exam Date | Signature Date |
| Address 2 | Physician Signature | |
| City, State, Zip | | |
| Phone | Fax | |

## LIST OF MEDICATIONS

Use this space to list any medications this individual will need while staying at Camp Courageous. Please include medications that will need to be administered by a member of the nursing staff, and those which the individual will be using themselves.

***Include all supplements and medications of all forms, both prescription and non-prescription.***

**To expedite arrival check-in at Camp Courageous:**

1. Deliver medications to Camp Courageous ahead of the scheduled date.
2. Notify the nursing department of all changes in prescriptions as soon as possible - at least two weeks ahead of the check-in date.
3. Send only the number of doses your camper will need during their stay **plus one spare dose**
4. Package and label the medications with:
   - A. The prescribed individual's name
   - B. Name of the medication
   - C. Dosage of the medication
   - D. Frequency and times the medication is to be taken

**Common Terminology**

- BID = Two Times Daily
- TID = Three Times Daily
- QID = Four Times Daily
- PRN = As Needed
- GTT = Drop
- OU = Each Eye
- SUPP = Suppository
- BS = Blood Sugar
- RT = Right
- LT = Left
- 15ml = One Tablespoon
- 5ml = One Teaspoon
- Times:
  - 07 = 7 AM
  - 08 = 8 AM (breakfast)
  - 09 = 9 AM
  - 10 = 10 AM
  - 11 = 11 AM
  - 12 = 12PM (lunch)
  - 13 = 1 PM
  - 14 = 2 PM
  - 15 = 3 PM
  - 16 = 4 PM
  - 17 = 5 PM (dinner)
  - 18 = 6 PM
  - 19 = 7 PM
  - 20 = 8 PM
  - 21 = 9 PM
  - 22 = 10 PM
  - HS = Bedtime

| MEDICATION NAME | DOSAGE | FREQUENCY | TIMES |
|---|---|---|---|
| Example: Dilantin chewable | 50mg - 1 tablet | QID | 08, 12, 17, hs |
| Example: NovoLog flex pen injection | 12 units | TID, with food | 08, 12, 17, |
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