

Camp Costanoan

Via Services

2851 Park Ave, Santa Clara, CA 95050

Phone (408) 243-7861

Fax (408) 243-0452

Via  Services*Special lives ... special challenges ... special needs***MEDICAL FORM TO BE COMPLETED****BY A LICENSED PHYSICIAN****Please note:**

This form is good for two years from the date EXAMINED, not date form is signed.

Camper Name: _____

HEALTH EXAMINATION BY LICENSED PHYSICIANI have examined the above individual. **Date examined:** _____ Form expires two years from THIS date.In my opinion, the above individual's condition **does** **does not** (check one) allow his/her participation in an active camp program.

Camper's disability: _____ Camper's functional mental age: _____

Disability involves:

- | | | | |
|------------------------------------|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Legs | <input type="checkbox"/> Vision | <input type="checkbox"/> Communication | <input type="checkbox"/> Behavior |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Hearing | <input type="checkbox"/> Speaking | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hands | <input type="checkbox"/> Coordination | <input type="checkbox"/> Understanding | _____ |
| <input type="checkbox"/> Trunk | <input type="checkbox"/> Breathing | <input type="checkbox"/> Learning | _____ |
| <input type="checkbox"/> Head/Neck | | <input type="checkbox"/> Social Adjustment | |

HEALTH HISTORY

(Check, if applicable, giving approximate dates)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Defect/Disease _____ | <input type="checkbox"/> Bleeding/Clotting Disorders _____ | <input type="checkbox"/> Asthma _____ |
| <input type="checkbox"/> Frequent Ear Infections _____ | <input type="checkbox"/> Hay Fever _____ | <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Measles _____ |
| <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> German Measles (Rubella) _____ | <input type="checkbox"/> Mumps _____ | <input type="checkbox"/> Mononucleosis _____ |
| <input type="checkbox"/> Downs Syndrome | <input type="checkbox"/> Atlantoaxial Dislocation _____ | | |

ALLERGIES

Medicine (List) _____

Aspirin Y N Penicillin Y N Insects _____ Food _____ Other _____SEIZURES: Y N Type & frequency _____

Date of Last seizure _____

MEDICATIONS (Please PRINT. Attach another sheet if necessary)

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

RECOMMENDATIONS / RESTRICTIONS AT CAMP:

Treatment plan to be continued at camp: _____

Activity restriction, if any _____

Medically prescribed meal plan or dietary restrictions: _____

IMMUNIZATION HISTORY:

Required immunizations must be determined locally. Please record the date (month and year) basic immunizations and most recent booster doses.

- | | | | | | | |
|--------------------------------------|--------------------------------|---------------------------------------|--------------------------------------|------------------------------------|----------------------------------|--|
| Polio | At age: | <input type="checkbox"/> 2 - 4 months | <input type="checkbox"/> 15 months | <input type="checkbox"/> 5 years | <input type="checkbox"/> Other | (date) _____ |
| Diphtheria/ Pertussis/Tetanus | At age: | <input type="checkbox"/> 2 - 4 months | <input type="checkbox"/> 6 months | <input type="checkbox"/> 18 months | <input type="checkbox"/> 5 years | <input type="checkbox"/> 13-15 years <input type="checkbox"/> Adult (date) _____ |
| Measles/Mumps/Rubella | At age: | <input type="checkbox"/> 12-15 months | <input type="checkbox"/> 11-12 years | <input type="checkbox"/> Other | (date) _____ | |
| Hepatitis | <input type="checkbox"/> Hep A | (date) _____ | (date) _____ | <input type="checkbox"/> Hep B | (date) _____ | (date) _____ (date) _____ |
| Pneumococcal | (date) _____ | (date) _____ | (date) _____ | | | |
| Tuberculin test given | _____ | (most recent) | <input type="checkbox"/> Neg | <input type="checkbox"/> Pos | | |

Licensed Physician's Signature: _____ Phone: _____

Address: _____
Street & Number City State Zip Code

Date of Form Completion: _____ By: _____