CAMP GLOW 2025 MEDICAL FORM

Part I:
Applicant Information:

Name of Applicant: _____

Name of Person Completing this Application: _____

Organizational Affiliation: (if any): _____

Name of Primary Physician: _____

Address: _____City:_____ State: _____ Zip:_____

Phone Number:_____

Primary insurance: _____Phone_____

Insured name_____Group #_____ Policy #_____

Health History

ALLERGIES: ☐ No Allergies
Allergies to: ☐ Medication ☐ Food ☐ Environmental ☐ Insects

Please specify: _____

Have you had an adverse reaction to: ☐ antibiotics ☐ adhesive tape ☐ aspirin ☐ iodine ☐ Tylenol ☐ latex ☐ other medications ☐ other

Last Tetanus: _____(Required)

PAST MEDICAL HISTORY: Have you **EVER** had… check all that apply.

☐ Eye Problems/Foreign Body	☐ High Blood Pressure	☐ Joint Replacement	☐ Migraines
☐ Color Blindness	☐ Liver Problems	☐ Arthritis	☐ Seizures
☐ Ear or Hearing Problems	☐ Jaundice	☐ Bipolar	☐ Ruptured Disc
☐ Glasses/Contacts	☐ Depression	☐ Cancer	☐ Sports Injuries
☐ Nutrition Problems	☐ Hepatitis	☐ Radiation/Chemo	☐ Muscle Problems
☐ Nose Problems	☐ Stomach Problems	☐ Carpal Tunnel	☐ Sprains or Strains
☐ Mouth/Oral Problems	☐ Stomach Ulcers	☐ Diabetes	☐ Any Prior Work Injury
☐ Lung Problems	☐ Colitis	☐ Gout	☐ Chiropractic Care

☐ Lung Infection	☐ Urinary Problems	☐ Hay Fever	☐ Tendonitis
☐ Asthma	☐ Kidney/Bladder Infection	☐ Hives	☐ Incontinence
☐ Emphysema	☐ Kidney Disease	☐ Anxiety	☐ Neurological Problems
☐ Pacemaker/Stent	☐ Kidney Stones	☐ Substance Abuse	☐ Head/Spine Problems
☐ Angina/Chest Pain	☐ Bleeding Problems	☐ Hernia	☐ Prior Back Strains
☐ Heart Disease	☐ Loss of Consciousness	☐ Skin Problems	☐ Metal in any part of body

Please write/print legibly. Once the lines are full, please use the back of this form when answering below.

Please explain any boxes checked above: _____

_____

_____

Please provide information concerning any dietary restrictions: _____

_____

Please indicate any restrictions related to physical activities, exposure to the sun, etc: _____

_____

Please explain any behavioral concerns: _____

_____

Please explain any mobility or other limitations: _____

_____

MEDICATION INFORMATION
Please Print

Medications are to be administered by (please check one):
_____Camp Nurse
_____Self-administered by camp participant (please list all medications)

DRUG*	STRENGTH	DOSAGE	TIMES GIVEN

*PLEASE INCLUDE OVER THE COUNTER MEDICATIONS

Name:_____

SPECIAL INSTRUCTIONS: _____

_____

_____

***Does camp participant use c-pap machine?** ☐ **Yes** ☐ **No**
(Note: Participant must have ability to operate c-pap independently)

ATTENTION CAREGIVERS:

The following needs to be signed by the applicant's physician/nurse practitioner:

Dear Physician/Nurse Practitioner:

Please read the above health information concerning_____**, noting**
Name

any errors, incorrect or missing information, based on your current knowledge of patient's history.

Based on above named patient's history and last visit with you, on_____**,**
he/she has an acceptable health status to attend Camp GLOW for one week this summer.

_____ _____

Physician/Nurse Practitioner (Signature/Date) **Physician/Nurse Practitioner (printed)**