



CAMP GLOW 2026 MEDICAL FORM

ARCHDIOCESE OF BALTIMORE
 Department of Evangelization
 320 Cathedral Street
 Baltimore, MD 21201

Camper Information

Name of Camper:			
Name of Person Completing this Form:			
Organizational Affiliation (if any):			

Name of Primary Physician:			
Address:			
City, State Zip:		Phone:	
Primary Insurance:		Policy #	
Insured Name:		Group #	

Health History

Allergies:	<input type="checkbox"/> NONE <input type="checkbox"/> Medication <input type="checkbox"/> Food <input type="checkbox"/> Environmental <input type="checkbox"/> Insects			
Please Specify:				

Have you had an adverse reaction to:	<input type="checkbox"/> antibiotics <input type="checkbox"/> adhesive <input type="checkbox"/> aspirin <input type="checkbox"/> iodine <input type="checkbox"/> Tylenol <input type="checkbox"/> latex <input type="checkbox"/> Other medications <input type="checkbox"/> other			
Specify other:				
Date Last Tetanus:				(Required)

Does camp participant use c-pap machine?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
--	------------------------------	-----------------------------	--

(Note: Participant must have ability to operate c-pap independently)

Past Medical History:

Have you EVER had... (check all that apply)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Eye Problems/Foreign Body | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Ear or Hearing Problems | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Bipolar | <input type="checkbox"/> Ruptured Disc |
| <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sports Injuries |
| <input type="checkbox"/> Nutrition Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation/Chemo | <input type="checkbox"/> Muscle Problems |
| <input type="checkbox"/> Nose Problems | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Sprains or Strains |
| <input type="checkbox"/> Mouth/Oral Problems | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Any Prior Work Injury |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Colitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Chiropractic Care |
| <input type="checkbox"/> Lung Infection | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney/Bladder Infection | <input type="checkbox"/> Hives | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Neurological Problems |
| <input type="checkbox"/> Pacemaker/Stent | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Head/Spine Problems |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Hernia | <input type="checkbox"/> Prior Back Strains |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> 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:

Special Instructions:

MEDICATION INFORMATION

Please Print

This form must be completed fully in order for authorized staff members to administer the required medication or for the camper to self-administer medication. If the camper does not have legal capacity to make health care decisions on their own behalf, the signature of a legal guardian is required.

Medications are to be administered by (please check one):

Camp Nurse

Self-administered by camp participant (please list all medications)

<u>DRUG*</u>	<u>STRENGTH</u>	<u>DOSAGE</u>	<u>TIMES GIVEN</u>

*Please INCLUDE over the counter medications.

I give permission for the authorized staff member to administer the medications listed above or to supervise the camper in self-administration. I certify that I have legal authority to consent to medical treatment for (name of camper) _____, including administration of medication at the facility.

Print Name of Legal Guardian: _____

Signature of Legal Guardian Date

Name:	
-------	--

Attention Caregivers: The full document needs to be reviewed and signed below by the applicant's physician/nurse practitioner.

Dear Physician/Nurse Practitioner:

Please read the above health information concerning camp participant _____ (name), noting 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 _____ (date), he/she has an acceptable health status to attend Camp GLOW for one week this summer 2026.

Print Name of Physician/Nurse Practitioner: _____

Signature of Physician/Nurse Practitioner

Date