



## Medical Examination Summary

Easterseals Tennessee Camp  
960 Simpson Maddox Pkwy, TN 37090  
Phone: (615) 444-0597 ext. 420  
Fax: (615) 444-1251

**Date of Examination:** \_\_\_\_\_

**Date Form Completed:** \_\_\_\_\_

**APPLICANT'S NAME:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_ **Gender::** \_\_\_\_\_

**IMPORTANT NOTE TO PHYSICIAN:** The information requested in this form is extremely important to the applicant's health and safety during participation at Easterseals Camp. In most cases the level of activity will be higher than normal and the daily routine will be different. Camp has a health center on site staffed by a Camp Nurse; however, we are able to provide only routine, basic health care. Therefore, it is crucial that care be taken in thoroughly completing this form. Thank you for your assistance in this matter.

### **PLEASE CHECK THE FOLLOWING:**

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Vision: \_\_\_\_\_ Hearing: \_\_\_\_\_  
Eyes: \_\_\_\_\_ Ears: \_\_\_\_\_ Nose: \_\_\_\_\_ Throat: \_\_\_\_\_ Teeth: \_\_\_\_\_ Lungs: \_\_\_\_\_ Heart: \_\_\_\_\_  
ABD.: \_\_\_\_\_ Gent.: \_\_\_\_\_ Skin: \_\_\_\_\_ Lymph Nodes: \_\_\_\_\_

**Primary Diagnosis:** (please be specific) \_\_\_\_\_ **Date of Onset:** \_\_\_\_\_

Secondary diagnosis (related or unrelated to primary diagnosis): \_\_\_\_\_

Other Medical conditions (e.g. ileostomy): \_\_\_\_\_

Any infectious diseases? Please name and give recommendations: \_\_\_\_\_

Does the applicant have epilepsy? \_\_\_\_\_ Type of seizures \_\_\_\_\_

Frequency: \_\_\_\_\_

Has the applicant been identified as developmentally delayed? \_\_\_\_\_ If yes please indicate level:

Mild (IQ 69-55) \_\_\_\_\_ Moderate (IQ 54-40): \_\_\_\_\_ Severe/profound (IQ below 40): \_\_\_\_\_

**DOES APPLICANT HAVE ANY ALLERGIES?** \_\_\_\_\_ **Allergic to:**

Bee Sting or insect bite \_\_\_\_\_ Pollen \_\_\_\_\_ Serum: \_\_\_\_\_ Food: \_\_\_\_\_

Drugs (penicillin, etc.): \_\_\_\_\_ Other: \_\_\_\_\_

Signs of allergic reaction: \_\_\_\_\_

Recommended treatment: \_\_\_\_\_



**DIET:** Does applicant have any medically prescribed meal plan or dietary restrictions? Please describe: \_\_\_\_\_

**CAMP ACTIVITIES:** Please include any instructions or precautions to be taken during routine camp activities. These activities may include swimming, horseback riding, canoeing and sports: \_\_\_\_\_

Please list any activities in which the applicant may NOT participate: \_\_\_\_\_

**Reactions that might be expected with irregularities in:**

A. Environment \_\_\_\_\_

B. Diet \_\_\_\_\_

C. Medication \_\_\_\_\_

D. Stress \_\_\_\_\_

**Medical History:**

Dates of Immunizations:

Measles, mumps, rubella: \_\_\_\_\_ Tetanus-diphtheria Toxoid: \_\_\_\_\_ H. influenza: \_\_\_\_\_

Pneumonia: \_\_\_\_\_ Last TB Skin Test Date: \_\_\_\_\_

Results: \_\_\_\_\_

DPT series: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

Polio series: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ Chicken Pox \_\_\_\_\_

Hepatitis B: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Last dates applicant has had:

Chicken pox: \_\_\_\_\_ Mumps: \_\_\_\_\_ Diphtheria: \_\_\_\_\_ German measles: \_\_\_\_\_

10 Day measles: \_\_\_\_\_ Whooping cough: \_\_\_\_\_ Strep throat: \_\_\_\_\_

Pneumonia: \_\_\_\_\_ Rheumatic fever: \_\_\_\_\_ Mononucleosis: \_\_\_\_\_

Does applicant have a history of:

Ear infections: \_\_\_\_\_ Strep throat: \_\_\_\_\_ Gastric upsets: \_\_\_\_\_ Mono: \_\_\_\_\_

UTI: \_\_\_\_\_ Kidney problems: \_\_\_\_\_ Eczema: \_\_\_\_\_ Hypertension: \_\_\_\_\_

Diabetes: \_\_\_\_\_ Emotional upset: \_\_\_\_\_ Other: \_\_\_\_\_



**SIGNATURE OF PRIMARY HEALTH CAREGIVER:** \_\_\_\_\_

*The following information could be crucial in an emergency situation. Please print or type clearly.*

**NAME OF PRIMARY HEALTH CAREGIVER:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**Medical professional to contact in the event applicant's Primary Health Caregiver cannot be reached:**

Name and title: \_\_\_\_\_

Phone number: \_\_\_\_\_

Address: \_\_\_\_\_