



The 30th year of Fellowship in a Caring Community

Camp Koinonia 2007 Medical History Form

To be completed by camper's parent/guardian. **PLEASE PRINT!**

Camper's Name: _____ Birth date: _____ Age: _____ Height: _____ Weight: _____

Last surgery & reason: _____

Date: _____ by whom? _____

Does your child have seizures or convulsions? () YES () NO

Type: _____ Frequency: _____

Date of last seizure: _____

In general, what tends to bring on a seizure? i.e. being overly excited, overly tired, etc. _____

What steps are taken at home once the child has a seizure? _____

Is your child medicated for seizures? () YES () NO

Medication: _____

Does your child have menstrual periods (females)? () YES () NO

Cramps? () YES () NO

Does your child have allergies? () YES () NO

(If yes, please indicate recommendations)

Recommendations:

Pollen _____	_____
Serum _____	_____
Food _____	_____
Bee/Insect _____	_____
Medications _____	_____
Other allergies _____	_____

Primary Disabling Condition(s): (please be specific, attach additional paper if necessary): 1.) _____
2.) _____
3.) _____

Date of Onset: _____ Degree: () Slight () Moderate () Severe

Have you been told by a physician that your child should not engage in strenuous activities (running, physical games, etc.)? () YES () NO

Typical camp activities are horseback riding, dancing, sports and games, canoes, cooking, ropes course elements and nature crafts.
Please describe or attach any instructions or precautions that should be taken during routine camp activities: _____

Please list any camp activities in which your child should **not** participate in:

Does your child use:
Wheelchair? () YES () NO
Crutches? () YES () NO
Walker? () YES () NO

Does your child use any special equipment such as orthopedic devices, glasses, contacts, dentures, or earplugs? () YES () NO
If yes, what devices? _____
(Please Note: If any of these devices are used, the camper must bring them to camp)

Is your child catheterized? () YES () NO
If yes, what type of assistance is needed? _____

Does your child require tube feeding? () YES () NO
If yes, please provide any special instructions: _____

Is your child prone to emotional upsets? () YES () NO
What seems to cause the emotional upsets? _____
If your child does have emotional upsets, what is normally done at home to calm them down? _____

Does your child exhibit any unusual or out of the ordinary behavior when he/she becomes very excited, overly tired, frustrated, or agitated? () YES () NO
Explanation _____

Does your child have trouble communicating wants and needs? () YES () NO
Explanation _____

Does your child have trouble going to sleep? () YES () NO

Does your child sleep walk? () YES () NO

Does your child have nightmares? () YES () NO

If yes to any of the above questions, what actions are taken to help the child get a good night sleep? _____

At home, we treat the following by:

Constipation _____

Headaches _____

Sore throat _____

Cold _____

Upset stomach _____

Does the camp nurse have permission to administer over-the-counter medications to your child, for any of the above? () YES () NO

Are daily bowel movements common for your child? () YES () NO

If NO, how frequent? _____

Does your child's "bathroom habits" change in different environments?

() YES () NO please explain _____

Does your child wear diapers or pull-ups? () YES () NO

Explanation(s), if needed _____

Please provide the following information about your child's skills in self care, gross and fine motor skills, getting along with others, functional speech, and safety orientation. Indicate if your child can perform the requested skill and/or explain any assistance needed. **PLEASE PRINT.**

PERSONAL CARE	YES	NO	EXPLANATION OF ASSISTANCE NEEDED
Is toilet trained			
Washes hands and face			
Brushes teeth			
Takes shower			
Combs/brushes hair			
Dresses self:			
Underwear			
T-shirt/jacket			
Pants/shorts			
Shoes & socks			
Other			
MOBILITY/FINE & GROSS MOTOR SKILLS	YES	NO	EXPLANATION OF ASSISTANCE NEEDED
Rolls over and sits up			
Independently uses wheelchair			
Transfers from seat to chair/from bed to chair			
Uses crutches/walker			
Grasps and releases objects			
Forms objects with clay			

MOBILITY/FINE & GROSS MOTOR SKILLS (CONTINUED)	YES	NO	EXPLANATIONS OF ASSISTANCE
Colors with crayons or markers			
Other			
MEALTIME NEEDS	YES	NO	EXPLANATION OF ASSISTANCE NEEDED
Can feed self with fork/spoon independently			
Can feed self with finger foods			
Has difficulty swallowing			
Can hold cup or glass			
Drinks from cup or glass			
Uses adaptive utensils			
Knows when he/she is full			
Is tube fed			
Prefers to drink out of a straw.			
Other feeding instructions			
SAFETY CONCERNS	YES	NO	EXPLANATION OF ASSISTANCE NEEDED
Tends to run away from caretaker			
Shows appropriate fear of unsafe situations			
Pays attention to danger safety issues			

SAFETY CONCERNS (CONTINUED)	YES	NO	EXPLANATION OF ASSISTANCE NEEDED
Follows simple directions			
Child engages in self-abusive behavior			
Child engages in abusive behavior towards others			
SOCIAL SKILLS	YES	NO	EXPLANATION OF ASSISTANCE NEEDED
Makes wants known by speech			
Makes wants known by gestures			
Enjoys playing with others			
Follows simple directions			
Asks for help			
Says 'Please' and 'Thank you'			
Responds to facial expressions			
Responds to praise and smiles			
Is the child outgoing?			
Is the child reserved?			

