

Camp Flame Catcher
Epilepsy Foundation of Greater Cincinnati
895 Central Avenue, Suite 550
Cincinnati, OH 45202

MASTER MEDICAL FORM

****CONFIDENTIAL****

Please be aware that the information requested from your physician by this Master Medical Form is to be used solely in our efforts to provide as safe and healthy of an environment as we reasonably can. Neither the absence nor the nature of any response given on this form will determine your acceptance into the program. We are not seeking the disclosure of any information of which the confidentiality is protected by law except in accordance with that law.

Applicant's Information:

Name: _____ Age: _____

Birthdate: _____ Sex: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Parent/Guardian names: _____

E-mail address: _____

To be completed by physician:

Primary Physician (please print): _____

Phone: _____

Neurologist (please print): _____

Phone: _____

Diagnosis: _____

Seizure Information:

Type(s): _____

Frequency: _____

Patterns: _____

Warnings: _____

Height: _____ Weight: _____ Normal blood pressure: _____

Normal temperature: _____

Vagus Nerve Stimulator? _____ yes _____ no

Prescribed Diastat? _____ yes _____ no Last time used: _____

Typically use after: _____

Past Medical History

	<u>Yes</u>	<u>No</u>	<u>If Yes, Describe</u>
Auditory Impairment	_____	_____	_____
Learning Disability	_____	_____	_____
Mental Impairment	_____	_____	_____
Psychological Impairment	_____	_____	_____
Speech Impairment	_____	_____	_____
Visual Impairment	_____	_____	_____
Cardiac Problems	_____	_____	_____
Diabetes	_____	_____	type: _____
<u>Circulatory Problems</u>	_____	_____	_____
PVD	_____	_____	_____
Postural Hypotension	_____	_____	_____
Hemophilia	_____	_____	_____
<u>Pulmonary</u>	_____	_____	_____

Asthma/COPD	_____	_____	_____
<u>Neurological Impairment</u>	_____	_____	_____
Hydrocephalus	_____	_____	_____
Has Shunt	_____	_____	_____
Sensory Loss	_____	_____	_____
Pain	_____	_____	_____
<u>Muscular Impairment</u>	_____	_____	_____
Contractures	_____	_____	_____
Weakness	_____	_____	_____
Degenerative Disc Disease	_____	_____	_____
<u>Skeletal Impairment</u>	_____	_____	_____
Spinal Column Injury	_____	_____	_____
Subluxing Joints	_____	_____	_____
Dislocating Joints	_____	_____	_____
Laminectomy/Fusion	_____	_____	_____
Scoliosis	_____	_____	degree/type: _____
Brace?	_____	_____	last x-ray: _____
Kyphosis/Lordosis	_____	_____	degree/type: _____
Spondylolisthesis	_____	_____	_____
Spinal Abnormality	_____	_____	_____
Osteoporosis	_____	_____	_____
Heterotrophic Ossification	_____	_____	_____
Joint Disease	_____	_____	_____
Cranial Defects	_____	_____	_____
Fractures	_____	_____	location: _____
Healed?	_____	_____	_____

Immunizations/dates: (Line indicates number of shots in series)

DPT Series: _____

Polio Series: _____

Hib: _____

MMR: _____

HepB: _____

Varicella: _____

Pneumococcal: _____

Meningococcal: _____

Other: _____

Comments:

Screenings:

(1) T.B. Skin Test or X-ray: Date _____ Negative ___ Positive ___

(2) Hepatitis B: HBsAG: Date _____ Negative ___ Positive ___

Antibody to Hepatitis B: Yes ___ No ___

(3) Sickle Cell: Date _____ Negative ___ Positive ___

(4) H.I.V.: Date _____ Negative ___ Positive ___

(5) Other Screenings/Information: _____

Has applicant been exposed to any communicable diseases in the last six months? _____

Name of disease & date: _____

Is applicant now free from apparent communicable disease? _____

Any recurring diseases (e.g., Malaria) _____

Other Disabilities or Chronic Illnesses _____

Allergies**

Food Allergies: _____

Medication Allergies: _____

Environmental Allergies: _____

What is the treatment if applicant is exposed to allergen? _____

**Any special precaution or treatments? _____

Current Medication and/or Food Supplement Schedule

MEDICATION OR FOOD SUPPLEMENT:	PURPOSE:	DOSAGE:	FREQUENCY:

Mobility Status:

1. Ambulation: Independent ____ Dependent ____
Walker ____ Cane ____ Crutches ____

Transfer Ability _____

Gait Pattern _____

2. Wheelchair: No _____ Electric _____ Manual _____

3. Orthotics: No _____ Yes _____ Describe: _____

4. Splints: No _____ Yes _____ Describe: _____

5. Prosthetics: No _____ Yes _____ Describe: _____

Recommendations concerning restriction of activity: (List and Explain)

Are there any injuries, past illnesses, recent surgeries or recurring medical problems that the Camp Dream Catcher staff should be aware of?

Physician approval to participate in Aquatics: Yes _____ No _____

Additional Comments:

Date of last complete Physical Exam: _____

Physician's Signature _____ Date: _____

Physician's Address _____

Phone: _____

Please return form as soon as possible to:

Epilepsy Foundation of Greater Cincinnati
Camp Flame Catcher
895 Central Avenue, Suite 550
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***Medical information is accepted for a two (2) year period for participants 6 years and older. It is the responsibility of the parent/guardian to inform the Epilepsy Foundation of Greater Cincinnati of any change in status.

Faxed Master Medical Forms Are Not Acceptable- Signatures Must Be Original (No Copies)

Thank You for Your Time