

Camp Dream 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 Dream Catcher  
895 Central Avenue, Suite 550  
Cincinnati, OH 45202

\*\*\*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