Elks Camp Grassick
PO Box F, Dawson, ND 58428
701-327-4251
campgrassick@gmail.com

Medical Form/Health History

Please Note: All individuals accepted for attendance at Elks Camp Grassick must receive a physical examination by a doctor before coming to camp. The Medical Physical Information form should be filled out completely by a physician and sent to camp prior to the individual's arrival at camp if possible. Attachment of the physical examination report would be beneficial during the screening and selection process, but if the cost of such a physical examination is a concern or if an individual's physical is typically scheduled closer to camp times, this form does not need to be filled out until after you know that this person has been accepted and it can be sent later or brought with the individual at check in.

Lice Check: No lice check form will be required. There is a space on the physical form that asks if the individual is free of lice and nits. If the individual or someone in the household has been exposed to lice prior to attending camp, please inform staff immediately. Thank you!

MEDICAL FORM/HEALTH HISTORY FOR ELKS CAMP GRASSICK

To be completed by the parent/guardian or caregiver. This portion should be sent to Camp Grassick with the application.

Name of Individual: _____ Gender: ☐Male ☐Female

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Primary Medical Diagnosis: _____

Secondary Medical Diagnosis: _____

Individual's Physician: _____

Clinic where Physician Works: _____ Phone#: _____

Family's Insurance Company: _____

Insurance #: _____

Medical Assistance # (If Applicable): _____

EPILEPSY AND/OR SEIZURE HISTORY

Epilepsy or any history of seizure disorder ☐ Yes ☐No

If yes, list seizure type: _____

Date of last seizure: _____

Controlled by medication ☐ Yes ☐No

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ALLERGIES & DIETARY RESTRICTIONS

(Check all that Apply)

☐No Known Allergies ☐Latex Allergies ☐ Epi Pen Required

☐Allergies to Medications: _____

☐Allergies to Food: _____

☐Seasonal or Environmental: _____

☐Allergies to Insect Bites or Stings: _____

List any special dietary needs:

VACCINES

Are all vaccines up to date? ☐ Yes ☐No Covid-19 Vaccine? ☐ Yes ☐ No

Date of last Tetanus vaccine: _____

MENTAL HEALTH

Depression (diagnosed) ☐ Yes ☐No Anxiety (diagnosed) ☐ Yes ☐No

Self-injurious behavior during the past year ☐ Yes ☐No

Aggressive behavior during the past year ☐ Yes ☐No

Describe any mental health concerns:

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ASSISTIVE DEVICES

Does the individual use assistive devices (check all that apply)?

☐ Orthotics	☐ Communication Device	☐C-Pap Machine
☐Crutches or Walker	☐Dentures	☐Glasses or Contacts
☐G-Tube or J-Tube	☐Hearing Aids	☐Implanted Device
☐Inhaler	☐Wheelchair	☐Other: _____

MEDICATIONS

Please list medications this person will be taking while at Camp Grassick or attach a list:

NOTE: Please bring medication to camp in their original containers with legible prescription labels or pre-packaged by a pharmacy. If medications are packed in med planners, please bring a list of medications, dosage and times.

Medication:	Time(s):	Dosage:	Special Instructions: (i.e., crushed)

Please check any medications this person may take if needed while at Camp Grassick:

☐ Tylenol/Acetaminophen ☐ Advil/Ibuprofen ☐ Benadryl ☐ Allergy medicine

☐ Cough Drops ☐Cough/Cold medicine ☐Pepto Bismol ☐ Any of the Above

Is there any OTC medicine that person should **NOT** take? _____

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HEALTH HISTORY

Please list any recent surgeries, infections, or serious illnesses:

Has the individual ever been diagnosed with or experienced any of the following conditions?

(Check all that apply)

☐Arthritis	☐Asthma	☐Bedwetting
☐Broken Bones	☐Bleeding/Clotting Disorders	☐Chicken Pox
☐Concussions	☐Diabetes	☐Dislocated Joints
☐Epilepsy/Seizure Disorder	☐Frequent Ear Infections	☐Hepatitis
☐Frequent Headaches/Migraines	☐Frequent Sinus Infections	☐Incontinence
☐Hearing Impairment	☐ Heart Defect/Disease	☐Measles
☐High Blood Pressure	☐Heat Illnesses	☐Mononucleosis
☐Loss of consciousness/Fainting	☐Mumps	☐Nightmares
☐Pneumonia	☐Sleepwalking	☐Spina Bifida
☐Stroke/TIA	☐Vision Impairment	

Please elaborate on any of the checked boxes if necessary:

Any other specific concerns or pertinent information concerning this child's health that the staff of Elks Camp Grassick should be aware of?

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MEDICAL PHYSICAL INFORMATION

(To be completed by a licensed medical professional qualified to conduct physical exams.)

Individual's Name: _____

D.O.B: _____ Height: _____ Weight: _____ Blood Pressure: _____

Vision: 20/40 or better: Left: ☐ Yes ☐No ☐N/A Right: ☐ Yes ☐No ☐N/A

Hearing: Left: ☐Responds ☐ No Response Right: ☐Responds ☐ No Response

Left Ear Canal: ☐Clear ☐Cerumen Right Ear Canal: ☐Clear ☐Cerumen

Left Tympanic Membrane: ☐ Clear ☐Perforation ☐ Infection

Right Tympanic Membrane: ☐ Clear ☐Perforation ☐ Infection

Oral Hygiene: ☐ Good ☐Fair ☐Poor

Thyroid Enlargement: ☐Yes ☐No Lymph Node Enlargement: ☐Yes ☐No

Heart Murmur: ☐Yes ☐No Heart Rhythm: ☐Regular ☐Irregular

Lungs: ☐Clear ☐Not Clear Abdominal Tenderness: ☐Yes ☐No

Kidney Tenderness: ☐Yes ☐No Abnormal Gait: ☐Yes ☐No

Spasticity: ☐Yes ☐No Tremor: ☐Yes ☐No

Upper Extremity Reflex: ☐Normal ☐Diminished ☐Hyperreflexia

Lower Extremity Reflex: ☐Normal ☐Diminished ☐Hyperreflexia

Neck & Back Mobility: ☐Full ☐Not Full – Describe:

Upper Extremity Mobility: ☐Full ☐Not Full – Describe:

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MEDICAL PHYSICAL INFORMATION CONTINUED

Lower Extremity Mobility: ☐Full ☐Not Full – Describe:

Upper Extremity Strength: ☐Full ☐Not Full – Describe:

Lower Extremity Strength: ☐Full ☐Not Full – Describe:

Free of Nits/Lice: ☐ Yes ☐No

Describe any abnormal findings:

Any other pertinent information concerning this individual's health that we should be aware of:

☐ This individual can participate in all activities at Camp Grassick with NO RESTRICTIONS.

☐ This individual can participate in all activities at Camp Grassick WITH RESTRICTIONS. (Please explain)

I have examined _____ and find him/her free of communicable diseases, free of nits and lice, and fit to attend Elks Camp Grassick if he/she is accepted.

Physician's Name: _____(print)

Clinic: _____ Phone #: _____

Address: _____

Signed: _____ Date: _____