



Easterseals Camp Challenge CAMPER MEDICAL FORM



(To be completed by a Licensed Medical Provider – 2 pages)

For Summer Camp 2027 this form must be signed by a licensed provider AFTER January 1, 2027

****UNLESS****

The camper is attending a weekend camp or Winter Camp AND did NOT attend in Summer 2026.

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY AND SIGNED & DATED TO BE VALID

Camper's Full Name: _____

Address: _____

DOB: / / Age: _____ Sex: _____ Weight: _____

Applicant's primary disability (Medical Diagnosis): _____

Secondary disability (if any): _____

Applicant is under the care of a physician for the following condition(s): _____

IMMUNIZATION HISTORY

Does the camper have all the recommended vaccines? Yes [] No [] Date of last Tetanus: _____

If no, explain _____

ALL eligible campers are ENCOURAGED to receive the COVID-19 vaccine*

ALLERGIES (Food, Medication, Plants, Insects) _____

Reaction Type

☐ Anaphylaxis ☐ Rash/Hives ☐ Upset Stomach ☐ Other: _____

DIETARY RESTRICTIONS Yes [] No []

If yes, explain: _____

FEEDING TUBE/G-TUBE Yes [] No []

NOTES AND ADDITIONAL COMMENTS (please include any other information, including restrictions and limitations that we should be aware of):

SEIZURES: Yes [] No [] Type _____ Date of last seizure: _____

Known Seizure Triggers: _____ Medication Controlled? Yes [] No []

NOTES AND ADDITIONAL COMMENTS (please include any other information, including restrictions and limitations that we should be aware of):

BOWEL HABITS: Frequency? _____ Preventive medications (e.g.: Miralax) _____

NOTES AND ADDITIONAL COMMENTS (please include any other information, including restrictions and limitations that we should be aware of):

MEDICATION: All medications, both prescription and OTC must be listed on the next page.

NO medications (prescription or over-the-counter), supplements, or vitamins will be given without a doctor's order.

Medication changes within the last 30 days? Yes [] No [] If yes, explain _____

CURRENT PRESCRIPTION MEDICATIONS TO BE TAKEN AT CAMP: (Attach pages as necessary)

NAME	DOSAGE	TIME GIVEN	REASON FOR TAKING

CURRENT OVER THE COUNTER MEDICATIONS TO BE TAKEN AT CAMP: (Vitamins, OTC Allergy Medication, etc.)

NAME	DOSAGE	TIME GIVEN	REASON FOR TAKING

Camp Challenge medical staff routinely administer the following over-the counter medications. Please check all medications that may be given to the camper on an as-needed basis.

☐ Camper may have ALL of the medications listed below

- | | | | |
|--|--|---|---|
| ☐ Acetaminophen 325mg | ☐ Ibuprofen | ☐ Barrier Cream (Zinc Oxide) | ☐ Eye Drops (Visine) |
| ☐ Diphenhydramine HCL | ☐ Glycerin Suppository | ☐ Antacid (Tums) | ☐ Pepto Bismal |
| ☐ Hydrocortisone Cream | ☐ Triple Antibiotic Cream | ☐ Aloe | ☐ Nasal Decongestant |
| ☐ Cold and Allergy Medicine | ☐ Unisom (Sleep Aid) | ☐ Bacitracin Ointment | |

PHYSICIANS STATEMENT THIS SECTION MUST BE FILLED OUT IN ITS ENTIRETY

- | | |
|---|--|
| Can the camper safely be in a 1:3 staff to camper ratio? | ☐ Yes ☐ No |
| Can the camper be outside for approximately 1 hour at a time? | ☐ Yes ☐ No |
| Can the camper safely sleep overnight in a cabin environment? | ☐ Yes ☐ No |
| Is the camper at excessive risk for dehydration? | ☐ Yes ☐ No |

I have examined the camp applicant. In my opinion, the camper's disability, health condition, and/or behavior:

Allows [☐] Does Not Allow [☐] his/her participation in an active camp program within the 1:3 staff to camper ratio.

The camper is specifically able to participate in the following activities:

- [☐] Swimming (Shallow-Water Pool)
[☐] Outdoor Activities lasting 45-60 minutes

This medical form is used for year-round camping programs and valid for one year. Is the camper's health likely to remain stable during that time?* [☐] yes [☐] no

May a camp representative contact the office with any questions/need for clarification? [☐] yes [☐] no

Caregiver Signature

*An updated form may be requested prior to extended camping programs

Licensed Physician's Signature

Physician Name (printed)

Date of Most Recent Examination

Today's Date

Physician Address: _____

City _____ State _____ Zip Code _____

Phone: () _____

Camper's Full Name: _____

Medical Form Revised 09.2026