Camp Daniel 2022 Medical Page

Mail completed to: Camp Daniel, W10541 Army Ln, Athelstane, WI 54104
OR email to medform@campdaniel.org

1. THIS FORM MAY NOT BE SUBSTITUTED WITH PRIOR YEAR FORM OR ANY OTHER FORM.
2. EVERY SECTION MUST BE FILLED OUT, OR IT WILL BE RETURNED.
3. Upon receipt of completed form, an email will be sent to the email address you logged in with.

This medical form must be completed & signed each year by a Doctor.
All applicants must have a medical exam within 12 months of camp start date.

1. Applicant's **Last** Name: _____ **First** Name: _____

2. Height: _____ ft _____ in Weight: _____ lbs. DOB: _____ / _____ / _____

Blood Pressure: _____ Pulse: _____

3. Medical **Diagnosis**: _____

_____

4. ALLERGY to Medication(s) & Reaction: _____

5. Other ALLERGY(s) & Reaction: _____

_____

6. Enter **Date** of last **Tetanus** shot _____ / _____ / _____ (Must be within the last 10 years)

7. Hospitalizations and/or surgeries within the last 12 months:

Date: _____ / _____ / _____ Reason: _____

Date: _____ / _____ / _____ Reason: _____

8. If camper has had any of the following conditions, please give **age at onset:**

Anemia _____ Diabetes _____ Seasonal allergies _____ High blood pressure _____ Tuberculosis _____

Seizures _____ Headaches _____ Chicken pox _____ Asthma _____ Other _____

9. If ANY history of seizers: Date of last seizure: _____ / _____ / _____ Kind of seizure: _____

List all medications/treatment applicant is CURRENTLY taking for seizures: _____

_____

10. Are there any blood/body fluid precautions we should know about? **Yes** or **No** (circle one)

If yes, describe: _____

11. Check any medications the medical staff may **NOT GIVE** applicant as needed:

( ) Ibuprofen ( ) Tylenol ( ) Maalox ( ) Decongestant ( ) Anti-diarrheal ( ) Antihistamine

( ) Pepto Bismol ( ) Cough syrup ( ) Milk of Magnesia ( ) Other _____

Signature of examining physician	Printed name of physician	Phone #	Date