**VOCATIONAL SUMMER CAMP 2021**
**HEALTH INFORMATION**

Hope SERVICES

**It is the responsibility of the parent/guardian to contact the Camp Directors regarding medical interventions.**

**ALLERGIES:** Does your camper have a physician's diagnosis of any of the following allergies? (check all that apply)

| NON-LIFE THREATENING | | | LIFE THREATENING (Requires Medical Documentation) | | |
|---|---|---|---|---|---|
| Food (List) | ☐ | | Food (List) | ☐ | |
| Bee/Insect | ☐ | | Bee/Insect | ☐ | |
| Environmental (List) | ☐ | | Environmental (List) | ☐ | |
| Animal | ☐ | | Animal | ☐ | |
| Shellfish | ☐ | | Shellfish | ☐ | |
| Peanuts | ☐ | | Peanuts | ☐ | |
| Dairy/Lactose | ☐ | | Dairy/Lactose | ☐ | |
| Latex | ☐ | | Latex | ☐ | |
| Other: | ☐ | | Other: | ☐ | |
| Describe past reactions: | | | Describe past reactions: | | |

**Epi-pens must be provided by the parent/guardian.**
**Does your child carry an epi-pen on their person?** ☐**Yes** ☐**No**

**HEALTH CONDITIONS:** Does your child have a physician's diagnosis of any of the following health conditions? ☐ **YES** ☐ **NO** (check all that apply)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ADD/ADHD (Physician Diagnosed) | | ☐ | | Muscular Dystrophy | | ☐ | |
| Autism | | ☐ | | Muscular/Skeletal | | ☐ | |
| Blood Disorder (Type) | | ☐ | | Neurological Concern | Mild / Severe | ☐ | |
| Cancer (Type) | | ☐ | | Nutritional Concern | Mild / Severe | ☐ | |
| Cerebral Palsy | | ☐ | | Orthopedic Concern | Mild / Severe | ☐ | |
| Circulatory Issues | | ☐ | | Osteogenesis Imperfecta | | ☐ | |
| Crohns Disease | | ☐ | | Post-Traumatic Brain Injury | | ☐ | |
| Cystic Fibrosis | | ☐ | | Reflux | | ☐ | |
| Diabetes, Type 1 | | ☐ | | Respiratory Condition (Regularly use Inhaler/Nebulizer) | | ☐ | |
| Diabetes, Type 2 | | ☐ | | Respiratory Condition (Seasonal/Exercise/Cold Induced) | | ☐ | |
| Emotional Concerns | Mild / Severe | ☐ | | Scoliosis | | ☐ | |
| Endocrine Disorders | Mild / Severe | ☐ | | Seizure Disorder (Active seizure activity in past 5 years) | | ☐ | |
| Gastrointestinal Condition | Mild / Severe | ☐ | | Seizure Disorder (No seizure activity in past 5 years) | | ☐ | |
| Heart Condition | Mild / Severe | ☐ | | Sickle Cell Anemia | | ☐ | |
| Hemophilia | | ☐ | | Skin Disorder | Mild / Severe | ☐ | |
| Hernia (Existing) | | ☐ | | Spina Bifida | | ☐ | |
| High Blood Pressure (Physician Diagnosed) | | ☐ | | Ulcer (Type) | | ☐ | |
| Hypoglycemia (Physical Diagnosed) | | ☐ | | Urological Condition | Mild / Severe | ☐ | |
| Kidney Condition | Mild / Severe | ☐ | | Von Willebrands Disease | | ☐ | |
| Leukemia | | ☐ | | Other Condition: | | ☐ | |
| Lupus | | ☐ | | | | | |

**IF YOU HAVE CHECKED ANY OF THE ABOVE HEALTH CONDITIONS, PLEASE TALK TO A CAMP REPRESENTATIVE**

**MEDICATIONS:** List any prescription or over-the-counter meds taken by student on a regular basis. If any, fill authorization to carry medication form.

| DRUG NAME | HEALTH CONDITION | TO BE TAKEN DURING CAMP? |
|---|---|---|
| | | ☐ Yes ☐ No |
| | | ☐ Yes ☐ No |
| | | ☐ Yes ☐ No |

*(Continue in the back if more space is needed.)*

**MEDICAL EQUIPMENT:** Does your child use any specialized medical equipment? (check all that apply)

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Catheterization | ☐ | | Helmet | ☐ | | Suction Machine | ☐ | |
| Cochlear Implant | ☐ | | Infusion Pump | ☐ | | Tube Feed | ☐ | |
| Crutches | ☐ | | Nebulizer | ☐ | | Walker | ☐ | |
| Ear Tubes | ☐ | | Orthopedic Device | ☐ | | Wheelchair | ☐ | |
| Existing Shunt | ☐ | | Location: | | | Vaso Stimulator | ☐ | |
| Glasses | ☐ | | Oxygen | ☐ | | Other (Specify Below): | ☐ | |
| Glucometer | ☐ | | PICC Line | ☐ | | | | |
| Hearing Aids | ☐ | | Pacemaker | ☐ | | | | |

Physician's Name: Physician's Phone Number:

In the event of a medical emergency, if you are unable to notify me or a temporary caregiver(s), I hereby authorize Hope Services representative to have my child, _____ (camper's name), transported to a clinic or to a hospital for emergency treatment. I will be responsible for all costs incurred.

Signature: Relationship to Student: Date:

**VOCATIONAL SUMMER CAMP 2021**
**HEALTH INFORMATION**
*Continuation*

| STUDENT | | | | |
|---|---|---|---|---|
| | Last Name | First Name | Middle Name | |
| | Date of Birth (MM/DD/YYYY) | | | ☐ Male ☐ Female Gender |

## SENSORY PROCESING

Does the camper struggle with sensory processing? ☐ YES ☐ NO

Please explain:

Would the camper benefit from a sensory room break? ☐ YES ☐ NO

If yes, what equipment would work best for the camper?

## HISTORY OF SEIZURES *(If applies)*

History of ongoing seizures? ☐ YES ☐ NO

Date of last occurrence:

Frequency:

Type of Seizure:

Duration:

Medication:

## HEARING

Please check all that apply:

| | |
|---|---|
| ☐ Deaf | ☐ Hearing Impaired |
| ☐ Uses hearing aids | ☐ Uses sign language |
| ☐ Frequent ear infections | ☐ No impairment |

Parent Signature: Date:

## BEHAVIORAL INFORMATION

Please check all that apply:

| | |
|---|---|
| ☐ History of verbal aggression | ☐ Camper has unusual fears |
| ☐ Physical aggression/assaults peers or staff | ☐ History of elopement, running away or wandering away from home, program or school |
| ☐ Self-injurious behavior | ☐ Other |
| ☐ Camper requires one-to-one supervision | |

Please explain all checked answers:

Other behaviors, please explain:

Has a behavior support plan? ☐ Yes ☐ No

If yes, please explain or attache a copy of Behavioral Support Plan

How can we encourage your camper to participate?

Parent Signature: Date: