

CAMP TIDNISH
CONFIDENTIAL
MEDICAL
REPORT

Campers not presenting this document WILL be refused

Camper's Name: _____

Date of Birth: _____

Address: _____

No white out/liquid paper on this form please. Two distinctly different handwritings are undesirable. (This is a legal document)

This form must be completed by the camper's physician and returned to:

Easter Seals Nova Scotia
c/o Camping Program
3670 Kempt Road
Halifax, Nova Scotia B3K 4X8

Please return by May 1st.

It is very important that the form arrives prior to the camping session as it contains necessary information for the medical staff.

Please note: This report is not to be mailed to the campsite and MUST arrive at the above address by the above-designated deadline.

CONFIDENTIAL MEDICAL REPORT

To the examining physician:

I hereby authorize you to release the information requested in this form to:

The staff of Camp Tidnish and of Easter Seals Nova Scotia who will treat this information with confidentiality.

Signature of Patient/Camper

Date_____

Signature of Primary Care Giver

Date_____

Date of Examination: _____

Please print or type:

1. Primary disability/illness/diagnosis: _____

2. Secondary disability/illness/diagnosis: _____

3. Medical History: (i.e., list and briefly describe any significant past or present medical illness with corresponding dates)

a) Medical illness: _____

b) Psychiatric illness: _____

c) Injuries: _____

d) Hospitalization: _____

e) Infectious disease: _____

4. List of current regular medications:

<u>Name</u>	<u>Dosage & Times Taken</u>	<u>Indication</u>

5. List PRN medications:

<u>Name</u>	<u>Dosage & Times Taken</u>	<u>Indication</u>

6. Current Immunization Status: (i.e., date of last Tetanus, Hepatitis B, etc.)

7. Does the patient's condition and/or treatment cause adverse reactions to:

Alcohol: ___ Yes ___ No

Certain Foods: ___ Yes ___ No

(If yes, please name:)

8. Please list all known allergies including medications:

9. Please elaborate fully on any significant abnormalities in the following systems:

Central Nervous System

Head and Neck

Cardiovascular

Respiratory

Gastro-intestinal (including bowel control)

Genito-urinary

Musculo-skeletal (including any limb dysfunction)

Dermatological

11. Physical examination

Height: _____

Weight: _____

Casual/sitting
Blood Pressure: _____

Visual Acuties: Rt. Lt.
uncorrected

corrected

Hearing Acuity Rt. Lt.

12. Further Comments/Special Considerations:

Signature of Examining Physician

Date

Name of Physician (Please Print): _____