CAMPER HEALTH RECORD ADDENDUM

Child's First and Last Name: ____

Camper Date of Birth: ________-_________-________ Male ☐ Female ☐

Parent/Guardians First and Last Name: ______________________________________

Address (street, city, state, zip)**:** ______________________________________

Home Phone: _______________________ **Cell Phone:** _______________________

By signing this Health Record Addendum, I voluntarily authorize the Down Syndrome Association of Greater Charlotte (DSAGC) and/or its authorized representatives or agents to use the information contained in this form for such purposes as it sees fit, such as making a determination for participating in DSA of Greater Charlotte, or DSA of Greater Charlotte sponsored, programs and activities and dispensing any such medication(s) as listed above. *****In the event of an acute illness or injury, the camper will need to obtain additional medical clearance within 10 days of camp using the form we provide.***

Parent/Guardian Authorization:

_______________________________ _______________________

Signature Date

THE FOLLOWING SECTION IS TO BE COMPLETED BY A HEALTHCARE PROFESSIONAL

Vital Signs:

Height:	Weight:	Pulse:	Resp Rate (resting):	BP (resting):

General Inspection:

Area	Normal	Findings/Deviations	Area	Normal	Findings/Deviations
Head			Heart		
Eyes/Vision			Abdomen/Hernia		
Nose			Skin		
Mouth/Teeth			Lymphatics		
Ears/Hearing			Spine		
Neck/Thyroid			Extremities		
Thorax/Lungs					

Health History (Check or Give approximate dates):

Conditions	Diseases	Allergies (dates not needed)
Frequent Ear Infections	Chicken Pox	Insect Stings
Heart Defect/Diseases	Measles	Penicillin
Convulsions	German Measles	Asthma
Diabetes	Mumps	Diet Allergies/Sensitivities
Bleeding/Clotting Disorders	Hepatitis	Specify
Hypertension	Varicella Zoster	Other
Mononucleosis		

Other Health Impairments not identified above:

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____

Medical Information:

Current Medications (Please see **Authorization of Medication Form** if medications will be necessary during camp)**:**____

____

____

Operations or Serious Injuries (with dates):

____

____

Is the patient prone to the following conditions and/or taking medication for such conditions?

Seizures/Convulsions: ☐ Yes ☐ No Bee Stings Reactions: ☐ Yes ☐ No

If yes, please comment: ____

____

Has the patient been exposed to a communicable disease in the last six months? ☐ Yes ☐ No

If yes, please comment: ____

____

Has an x-ray evaluation for atlanto-axial instability been done? ☐ Yes ☐ No

If yes, was the *atlanto-dens interval is 5mm or more (indicating atlanto-instability)? Please add further detail.*

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Immunization Dates:

Tetanus:	Rubeola:	Rubella:	Mumps:	Polio:

Hepatitis-B Vaccine Series Dates: ___________/_________/___________

List any known Food/Medication/Other Allergies:

____

____

Additional Health Information: ____

____

____

Are there any special mental or psychological treatments or special restrictions while at camp? If so, please let us know:

____

____

Is it your medical opinion that the applicant is able to participate in this Summer Camp? ☐ Yes ☐ No

Please include any limitations in your opinion:

____

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HEALTHCARE PROFESSIONAL AUTHORIZATION:

Print Name of Examining Health Professional	Street Address
Signature of Examining Health Professional	City/State/Zip Code
Date	Telephone Number