Confidential Medical Form
Joy Outdoor Education Center
Camp WEKANDU

INTRODUCTION

The attached information forms should be completed and delivered or mailed to the following address by June 1, 2025.

Cincinnati Children's Hospital Medical Center
ATTN: Daniel Lovell
Division of Rheumatology, ML4010
3333 Burnet Avenue
Cincinnati, OH 45229-3039

If the camper is on any medication prescribed by a physician, please remember to **PACK AN EIGHT-DAY SUPPLY.** Each prescription medication must be in the pharmacy container, properly labeled including the camper's name, medication name, and dose. All over-the-counter medications must be in the manufacturer's container with the name of the camper written on the container. Scheduled medications are dispensed at breakfast, lunch, dinner, and bedtime. The Camp Nurse will begin dispensing scheduled medications starting at supper the first camp day. Please make sure any medications due before that time are given before registration.

On the last day of camp (Friday) the Camp Nurse will dispense medications at breakfast. As part of the check-out process you will be given your child's medications so that you can give the lunch medications if there are any.

Medications should be kept separate from the suitcase and given to the camp nurse upon arrival at camp. NO prescribed or over-the-counter medications, including alternative medications and nutritional supplements, are permitted in the camper's possession without permission of the physician in attendance. All camper's medicines, vitamins, etc., will be kept by the nurse and dispensed according to your physician's written instructions

If the camper is currently using splints, crutches, walker, wheelchair, or scooter - these items **must** be brought to camp.

No child who has been exposed to a communicable disease (COVID, measles, mumps, chicken pox, etc.) should be sent to camp before the period of incubation has elapsed. If your child is ill on camp registration day they should not come to registration for camp. If there is any question about this, please consult your physician.

We assure you that excellent medical care will be provided during camp. A pediatric rheumatologist and nurse will be at the camp 24 hours per day and other staff of the CCHMC Rheumatology Team will visit daily. Should a child develop a special medical problem while at camp, the parents will be notified by telephone.

GENERAL INFORMATION

Camper's Name: _____ _____ _____
Last First Middle

Birth Date: _____/_____/_____ Sex: M [ ] F [ ] Age at Start of Camp_____

Parent/Guardian Name: _____

Home Address: _____City: _____ State: _____ Zip: _____

Daytime phone: (_____) _____-_____ Evening phone: (_____) _____-_____

EMERGENCY CONTACTS
(Must be completed)

If Parent/Guardian is not available in case of an emergency please notify.

FIRST CONTACT:

_____
Name Relationship

_____
Address City State

Phone: **(_____) _____-_____** Alternate Phone: **(_____) _____-_____**

SECOND CONTACT:

_____
Name Relationship

_____
Address City State

Phone: **(_____) _____-_____** Alternate Phone: **(_____) _____-_____**

NAMES OF PERSONS OTHER THAN PARENTS TO WHOM CHILD MAY BE RELEASED:

1. Name _____Relationship _____
2. Name _____Relationship _____
3. Name _____Relationship _____

INSURANCE INFORMATION

Primary Insurance Company: _____Policy Number: _____

Effective Date: ____/____/____ Name of person carrying insurance: _____

Secondary Insurance Company: _____ Policy Number: _____

Effective Date: ____/____/____ Name of person carrying insurance: _____

Medicaid or other third-party payer: _____Case Number: _____

GENERAL HEALTH HISTORY

ALLERGIES

	YES	NO
Asthma	___	___
Hay Fever	___	___
Poison Oak/Ivy	___	___
Insect stings	___	___
Foods	___	___
Penicillin	___	___
Aspirin	___	___
Other Drugs:	___	___

_____
_____
_____
_____

MEDICAL PROBLEMS

	YES	NO	DATES
Ear Infections	___	___	_____
Seizures	___	___	_____
Sleepwalking	___	___	_____
Bedwetting	___	___	_____
Fears/Phobias	___	___	_____
Hyperactivity	___	___	_____
*Head Lice	___	___	_____
Behavior Disorder	___	___	_____
Chicken Pox	___	___	_____
Measles	___	___	_____
German Measles	___	___	_____
Mumps	___	___	_____
Bleeding disorder	___	___	_____
Blood clots	___	___	_____
Hepatitis A	___	___	_____
Hepatitis B	___	___	_____
Separation Anxiety	___	___	_____

**** All children will be checked for head lice at registration. Anyone with head lice will be treated appropriately at that time.***

Indicate Operations/Serious Injuries and Dates:

1._____ Date: _____

2._____ Date: _____

Additional Suggestions/Information from Parent about general health:

_____

_____

_____

IMMUNIZATION HISTORY:

	YES	NO
Are school immunizations up to date?	_____	_____
Has child received the varicella (chicken pox) vaccination?	_____	_____
Has the child received the COVID vaccination?	_____	_____
Has the child received the COVID booster vaccination?	_____	_____

PERTINENT TO <u>FEMALE</u> CAMPERS ONLY:

Has this person menstruated?	_____	_____
If not, has she been told about menstruation?	_____	_____
If so, are her periods normal?	_____	_____

ADDITIONAL SPECIAL CONSIDERATIONS/INSTRUCTIONS: _____
_____

RHEUMATIC DISEASE HISTORY

Name of child's rheumatic disease: _____

Name of child's Rheumatologist: _____

Current problems and symptoms of rheumatic disease:
_____

_____

_____

How long has your child had a rheumatic disease?_____

Does your child have a physical and/or occupational therapy exercise program? YES_____ NO_____

<u>If yes</u>, please include a copy of the exercises that were prescribed. If you do not have a copy, describe these exercises and the frequency they should be performed on the reverse side of this sheet.

Does the camper wear/use splints or any other appliances?
YES_____ DAY_____ NIGHT_____
NO_____

What appliance/splint? _____ When? _____

SPECIAL DIET

Does your child have any special diet or food allergies/intolerances that will need attention while at Camp Wekandu?
YES_____
NO_____

If YES, please describe specifically:
_____
_____

MEDICATIONS

If medications are to be taken while at camp, please include instructions

Although we are happy to give medication injections at camp, for children who receive weekly or every other week injections, if possible, arrange for your child to receive their injection either prior to or after camp. If you have questions regarding your child's injection schedule please call our office (513-636-4676) to speak with a nurse.

MEDICATION NAME/ STRENGTH	DOSE (How many or How much)	WHEN (Breakfast, Lunch, Dinner, Bedtime)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(use reverse side of this sheet if you need more room for listing medications)
See reverse side_____

Can Camper have the following medications, if needed? (See #5 in Waiver section, where parent signature is required)

Acetaminophen (Tylenol) YES____ NO____
Antihistamine (Benadryl) YES____ NO____

NOTE: If any medication changes occur between the time of submission of this form and the start of camp, a written notification must be provided to the Camp by the child's physician.

GUIDELINES REGARDING CAMPER ACTIVITIES

The Camp counselors need guidelines regarding what kinds of activities each individual camper may be allowed to participate in, and which activities should be discouraged or prohibited. Please indicate whether you think your child should be permitted to participate in the various activities listed.

UNRESTRICTED means your child should be allowed to participate fully in any given activity.
PERMITTED WITH CAUTION means that your child should be permitted to do an activity, but should be watched to make sure he/she is careful and does not overdo.
NOT PERMITTED means the child cannot participate in the particular activity.

For each listed activity, please indicate with a check mark, whether your child's participation should be **UNRESTRICTED, PERMITTED WITH CAUTION,** or **NOT PERMITTED.** Please check only one possibility for each activity!

Please indicate whether the various walking activities should be undertaken with ambulatory aids (wheelchair, scooter, wagon, crutches, cane, walker, or walking stick).

	UNRESTRICTED	PERMITTED WITH CAUTION	NOT PERMITTED
▪ Long walks	_____	_____	_____
▪ Short walks	_____	_____	_____
▪ Walking to usual activities	_____	_____	_____
▪ Swimming	_____	_____	_____
▪ Fishing	_____	_____	_____
▪ Row boating/canoeing	_____	_____	_____
▪ Archery	_____	_____	_____
▪ Wall climbing	_____	_____	_____
▪ Ropes course	_____	_____	_____
▪ Non-competitive ball games	_____	_____	_____

Are there any special activities or areas you desire the camp staff to evaluate and/or work on during camp?

_____

APPROVAL OF PEDIATRICIAN OR RHEUMATOLOGIST

_____ is able to attend camp and participate in activities with the restrictions and recommendations as indicated under "Guidelines Regarding Camper Activities". I have reviewed the general medical history, the rheumatologic history and medication list. All data on this sheet is accurate at this time.

ADDITIONAL COMMENTS: _____

_____

Physician’s signature: _____ Date: _____

Physician’s printed name: _____

Physician’s phone number: _____

CAMP WEKANDU PERSONAL INFORMATION FORM

(To be completed by parent or guardian)

In order for the counselors to work more effectively with each camper, the following information is needed before the camp sessions begin.

Camper's name _____

Grade next school year _____ School _____

Nickname _____

This is my child's _____ year at Camp Wekandu

Does your camper have any fears? _____

_____

Please indicate what you hope your camper will gain from this Camp experience? _____

_____

_____

State any special needs your camper may have. _____

_____

_____

Revised 4-7-22 dl