

CHILD'S NAME: _____ AGE: _____

BIRTHDATE: _____ COMPLETED GRADE: _____

Is the participant able to function in a high-paced group setting without individualized attention (approximately 10 children to 1 counselor ratio)? YES ___ NO ___

If not, describe any limitations: _____

Is the participant able to understand and comply with the basic behavioral rules and regulations applicable to all campers (see attached Behavior Management Plan)? YES ___ NO ___

Is the participant able to participate in sports, games and other active recreational activities?

YES ___ NO ___

Please list any limitations: _____

Parent/Guardian:

Signature

Date

Medical Information:

Please check any that apply and add any comments:

___ Seasonal Allergies ___ Food Allergies ___ Asthma ___ Hearing Impaired ___ Vision Impaired

___ Diabetes ___ Health/Physical Restrictions ___ Down syndrome ___ ADD ___ ADHD ___ Autism

___ Cognitive Disabilities ___ Developmental Disabilities ___ Other (please describe in comment section)

Comments: _____

Does participant have or has had a history of seizures? YES ___ NO ___

If yes, what kind? (Grand Mal, Petit Mal, other and describe behavior after the seizure)

Date of last seizure: _____ Conditions or circumstances that may trigger a seizure:

MEDICATIONS:

Please identify type, dosage and time of **all*** medications participant is currently taking:

**All - whether they take them during camp hours or at home outside of camp hours:*

Name of Medication: _____ Treatment for: _____

Dosage: _____ Time: _____ am / pm

Name of Medication: _____ Treatment for: _____

Dosage: _____ Time: _____ am / pm

Name of Medication: _____ Treatment for: _____

Dosage: _____ Time: _____ am / pm

Name of Medication: _____ Treatment for: _____

Dosage: _____ Time: _____ am / pm