

EXPERIENCE  
ISANOVEL

7601 W Isanogel Road  
Muncie, Indiana  
47304

Phone: 765-288-1073  
Fax: 765-288-3103  
E-mail:  
epiazza@hillcroft.org



# HEALTH HISTORY AND EXAMINATION FORM 2010

This form must be received by the camp office at least two weeks prior to attendance at camp. All information must be reviewed and verified by a licensed physician or nurse practitioner for thoroughness and accuracy. Please keep a copy of this form for your records.

Camper Name: \_\_\_\_\_

## In Case of Emergency

(please list whom to notify in order of preference)

**#1**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

Other Phone: (\_\_\_\_) \_\_\_\_\_

**#2**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

Other Phone: (\_\_\_\_) \_\_\_\_\_

**#3**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

Other Phone: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_\_

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## Diagnoses:

Please check all that apply and write in other as applicable.

<input type="checkbox"/> ADHD/ADD	<input type="checkbox"/> Heart Disorder or Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Mild Intellectual Disability
<input type="checkbox"/> Autism	<input type="checkbox"/> Moderate Intellectual Disability
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Severe/Profound Intellectual Disability
<input type="checkbox"/> Constipation	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Depression	<input type="checkbox"/> Speech Impairment
<input type="checkbox"/> Diabetes (insulin dependent)	<input type="checkbox"/> Spina bifida
<input type="checkbox"/> Diabetes (non-insulin dependent)	<input type="checkbox"/> Visual Impairment
<input type="checkbox"/> Down syndrome	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Other: _____

## Allergies:

List all known and reactions

Does the camper carry/have an Epi-pen? \_\_\_\_\_

Does the camper carry/have an Inhaler? \_\_\_\_\_

Insect Bite/Sting: \_\_\_\_\_

Reaction: \_\_\_\_\_

Medication (s): \_\_\_\_\_

Reaction: \_\_\_\_\_

Latex: \_\_\_\_\_

Reaction: \_\_\_\_\_

Other: \_\_\_\_\_

Reaction: \_\_\_\_\_

## High Risk Areas (Chronic/Reoccurring Illnesses)

Please check all that apply and write in other as applicable.

<input type="checkbox"/> Bladder/Kidney Infection	<input type="checkbox"/> Skin Breakdown/Pressure Sores
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Skin Irritation/Rash
<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Eye Infection	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Sinus Infection	<input type="checkbox"/> Other: _____



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## SEIZURE INFORMATION

Type(s) of Seizures (Please Check All That Apply)

Absence     Atonic (Drop)     Clonic     Tonic     Tonic-Clonic

Other: \_\_\_\_\_

Frequency of Seizures: \_\_\_\_\_ Duration of Seizures: \_\_\_\_\_

PRN Medication for Seizures: \_\_\_\_\_

Instructions for PRN Medication: \_\_\_\_\_

Precipitating Factors/Triggers:

Overheating     Exhaustion     Menstruation     Stress     Other: \_\_\_\_\_

## DIABETES INFORMATION

Type of Diabetes     Insulin Dependent     Non-Insulin Dependent     Pre-Diabetic

If Insulin Dependent, can/does the camper administer his/her own shots? \_\_\_\_\_

Insulin Scale:

Time: \_\_\_\_\_ Range: \_\_\_\_\_ Coverage: \_\_\_\_\_

Time: \_\_\_\_\_ Range: \_\_\_\_\_ Coverage: \_\_\_\_\_

Time: \_\_\_\_\_ Range: \_\_\_\_\_ Coverage: \_\_\_\_\_

Time: \_\_\_\_\_ Range: \_\_\_\_\_ Coverage: \_\_\_\_\_

Instructions if Blood Sugar is Out of Range: \_\_\_\_\_

## TREATMENTS

Does the Camper use a Nebulizer?     Yes     No    If yes, camper must bring his/her own.

If yes, does the camper know how to operate the machine?     Yes     No

How frequently does the camper receive treatments?

Does the camper use home oxygen?     Yes     No    If yes, camper must bring his/her own.

Type of Delivery Device: \_\_\_\_\_ Setting of Liters: \_\_\_\_\_

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## DIGESTIVE INFORMATION

How frequently does the camper typically have bowel movements? \_\_\_\_\_

Does the camper have chronic \_\_\_\_ constipation and/or \_\_\_\_ diarrhea?

Please describe any known triggers for constipation and/or diarrhea: \_\_\_\_\_

Does the camper use \_\_\_\_enemas \_\_\_\_suppositories \_\_\_\_laxatives?

If yes, frequency: \_\_\_\_\_

Does the camper have a colostomy/ileostomy? \_\_\_\_yes \_\_\_\_no

## MEDICAL HISTORY AND RESTRICTIONS

Has the camper been hospitalized in the past 12 months? \_\_\_\_yes \_\_\_\_no

If yes, reason:

Does the camper have a shunt? \_\_\_\_yes \_\_\_\_no

If yes, special instructions:

Please list any activities in which the camper may not participate or attach precautions or special instructions for routine camp activities.

## VACCINATION RECORD



Vaccine	Year of Basic Immunization	Year of Booster Immunization
Diphtheria		
Pertussis		
Tetanus		
Tetanus/Diphtheria		
Oral Polio		
Measles (MMR)		
TB Test Date:	Type of Test:	Results:
If Positive, Explain Treatment:		

## PHYSICIAN'S STANDING ORDERS

Please indicate those medications which may be given at camp. Feel free to write in your preferences. Dosages appropriate to age/weight of person per product instructions will be given unless otherwise noted. Isanogel reserves the right to use generic equivalents of any drug.

**Please indicate:**  Liquid  Pill

Pain or Fever	<input type="checkbox"/> Tylenol <input type="checkbox"/> Tylenol Extra Strength <input type="checkbox"/> Ibuprofen	Constipation	<input type="checkbox"/> MOM <input type="checkbox"/> Miralax <input type="checkbox"/> Colace <input type="checkbox"/> Pericolace <input type="checkbox"/> Dulcolax suppository <input type="checkbox"/> Fleets enema
Cough	<input type="checkbox"/> Robitussin <input type="checkbox"/> Cough Drops <input type="checkbox"/> Notify MD for persistent cough	Skin Care	<input type="checkbox"/> Hydrocortisone or Caladryl <input type="checkbox"/> Neosporin or Bacitracin
Nausea	<input type="checkbox"/> Pepto-Bismol <input type="checkbox"/> Maalox	Sore Throat	<input type="checkbox"/> Chloraseptic Spray <input type="checkbox"/> Cepacol Lozenges <input type="checkbox"/> Sucrets Lozenges
Diarrhea	<input type="checkbox"/> Pepto-Bismol <input type="checkbox"/> Kaopectate <input type="checkbox"/> Imodium	Nasal/Chest Congestion	<input type="checkbox"/> Claratin <input type="checkbox"/> Dimetapp <input type="checkbox"/> Sudafed <input type="checkbox"/> Benadryl

## PRESCRIPTION MEDICATION

### Medication Packaging

Campers use medications that come in a variety of packaging. In order to comply with state medication administration laws, all medications must arrive at Isanogel in their original pharmacy packaging. Bubble packs, docudose and pill bottles are all acceptable packaging. Envelopes without a pharmacy label, pill trays, etc.. are not acceptable packaging.

### Medication Administration and Documentation

Upon arrival on check-in day, all campers and caregivers will meet with the nurse to review current medications, medical conditions, etc... Each camper and caregiver will be asked to review the medication administration schedule with the nurse. Isanogel will document medication administration on its own Medication Administration Record. Campers/caregivers should not expect Isanogel staff to document medication administration on his/her MAR. A copy of the Isanogel MAR will be available for campers upon check-out on closing day of camp.

**Licensed Physician's Signature:** \_\_\_\_\_

Printed Name of Licensed Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

Date of Examination: \_\_\_\_\_

