Submit This Form to EFMN ASAP

HEALTH EXAMINATION and MEDICATION ORDER FORM

***** If there are medication changes made AFTER May 5th , please fax the order to 651.287.2325 at EFMN. *****

Camper's Name ______________________________ Weight ____________Date Examined ___________________

In my opinion, the camper's condition ☐ does ☐ does not preclude his/her participation in an active camp program. In addition to epilepsy, this child is under the care of a physician for the following condition(s):

____

Comments/detail of above: ____

____

Seizure Classification Type #1________________________________Type #2 ______________________________

Type #3 ________________________________Type #4 ______________________________

Medication Name	Formulation Strength of tablet/capsule/liquid	Dose	Frequency	Most recent blood level of seizure medication

*****Physician: The above information will act as specific orders for camp staff to follow. Please enter as specific and detailed of information for medication, strength, dose and frequency. Please do not write statements such as "use as directed", etc. as abbreviations will not be accepted. Please include all medication, vitamins and/or supplements the patient is taking, prescribed and over-the-counter, scheduled and as needed.**

PLEASE TURN OVER.

To your knowledge does this child have any significant emotional or behavioral problems? ☐ Yes ☐ No

Please be specific and advise. ____

____

In your opinion, would the child successfully be able to participate in the following actions:

- Understand and follow directions
- Stay involved in camp activities (activity periods are up to 2 hours in length)
- Interact in a respectful way with other campers and staff
- Move from one area of camp or from one activity to another with limited supervision
- Participate in a week of mostly outdoor activities
- Be capable of independently performing activities of daily living, i.e. showering, brushing teeth, eating, etc.

☐ Yes ☐ No If no, please explain:

____

____

Have you recommended counseling? ☐ Yes ☐ No Is this child currently in counseling? ☐ Yes ☐ No

Comments: ____

If yes, name and address of counselor:

____

____

____

Licensed physician's signature _________________________________

Physician's printed name

Clinic name

Address

City State Zip

Phone number physician can be reached at

Date of form completion: _______________ *By:___________________________

Initial if completed by nurse or physician's assistant.

Submit This Form To EFMN ASAP – no later than May 5th.