UPWARD BOUND CAMP

HEALTH DISCLOSURE / PHYSICIANS APPROVAL

P.O. Box C, Stayton OR 97383
Phone (503) 897-2447 Fax (503) 897-4116
Email camp@upwardboundcamp.org

OFFICE USE ONLY
Received by:_____
Date received:_____
Date reviewed: _____

HEALTH DISCLOSURE / PHYSICIANS APPROVAL MUST BE COMPLETED BY ALL CLIENTS EVERY 2 YEARS..
Registration cannot be confirmed without current Health Disclosure / Physicians Approval on file.

DATE OF EXAM: _____

PATIENT INFORMATION – TO BE COMPLETED BY PRIMARY CARE PHYSICIAN

Patient Full Name: _____
Birth Date: _____ MM/DD/YYYY Gender: Male ◯ Female ◯ Other ◯
Height: _____ Weight: _____ BMI: _____ Blood Pressure: _____ BP HX: _____
Blood Glucose: _____ Date of Last Tetanus: _____ Immunizations Current: Y ◯ N ◯
Describe nature of disability (if known): _____
Date of last physician review of medications: _____ Has Current Prescriptions: Y ◯ N ◯

EMERGENCY CONTACT INFORMATION

First Name: _____ Last Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email: _____

PLEASE NOTE THE FOLLOWING AS BASIS FOR RECOMMENDATIONS/ RESTRICTIONS WHILE AT CAMP:
Upward Bound Camp has been providing ACA Accredited recreational opportunities for persons with intellectual and developmental challenges ages twelve through geriatric since 1978. Activities include but are not limited to: overnight sleeping in bunkhouse or tent style sleeping arrangements with others in peer group, large & small group recreational & educational activities in ratios of 1 staff to two-five campers. Campers choose to participate in a wide range of physical activities not limited to fishing, hiking, swimming, paddle boating, arts & crafts, drama, music, cooking outside, archery, dancing, table games, bowling, basketball, volleyball, nature study & horseback riding. All camp staff possess advanced first aid/CPR training, training in administrating oxygen, AED and epinephrine. There is an EMT & nurse on duty 24 hours.

INDICATE SIGNIFICANT FINDINGS / CONDITIONS – TO BE COMPLETED BY PRIMARY CARE PHYSICIAN

Eyes: _____ R _____ L Ears: _____ R _____ L Nose/Throat: _____
Spine: _____ Legs: _____ Feet: _____ Arms/Wrists: _____ Skin/Scalp: _____ Abdomen: _____
Genitalia: _____ Chest: _____ Heart: _____ Lungs: _____ Teeth: _____
General Disposition: _____
Significant Health History: (Swallowing difficulties, heart condition, fragile bones, allergic reactions, asthma, tubes in ears, bleeding/ clotting disorders, chronic UIs, Hepatitis, appendectomy, etc) _____
Childhood / Past Illness: _____
Please note any common PRN medication(s) NOT recommended or specifically contraindicated for this patient: _____
_____
Observations or recommendations for residential care needs: _____
Supportive device(s) / equipment needed / recommended: _____
Is client currently under the care of a mental health professional? ◯ Y ◯ N If YES – who: _____
Is client currently under the care of a dentist or orthodontist? ◯ Y ◯ N If YES – who: _____
Please list past serious injuries / bones / breaks or operations: _____
Please list any conditions requiring hospitalization in past ten years: _____
_____

◯ I have examined the person herein described on _____ (date) and have reviewed the health history information provided. It is my opinion that this camper is physically able to engage in camp activities, except as noted: _____

◯ I have examined the person described herein and have reviewed the health history information provided and have the following reservations regarding camp attendance: _____

Physician Name Printed: _____ Phone: _____ Email: _____
Address: _____ City: _____ State: _____ Zip: _____
Physician Signature: _____ Date: _____