Camper Medical History

Diet:
☐ Typical ☐ Gluten-free ☐ Vegetarian ☐ Vegan ☐ Diabetic ☐ Lactose Intolerant
☐ Other: _____

Allergies: (Check all that apply)
☐ None ☐ Pollen ☐ Poison Ivy ☐ Latex ☐ Animals ☐ Bee/Insects ☐ Food ☐ Medication
☐ Peanuts ☐ Other: _____
If allergic to medications or food, please list: _____
_____
_____
Describe any allergic reactions: _____
_____
_____

Medical Needs:
Do we need to be aware of any specific medical needs or concerns regarding your camper? For example, seizures, mobility issues, respiratory issues, etc.

_____
_____
_____
_____
_____

Sleeping Behavior:
☐ Typical sleeping habits ☐ Has trouble going to sleep ☐ Has nightmares ☐ Wets bed
☐ Sleepwalks ☐ Runs away ☐ Special routine, please explain: _____
_____
Usual bedtime: _____ Usual wake up time: _____

Medications:
Please describe any medications your camper is taking, including prescriptions, over-the-counter medications, supplements, vitamins, etc. Be sure to include amount, frequency and time of day.

_____
_____
_____
_____
Does the Indiana Donor Network nurse have permission to give your child over-the-counter medications?
☐ Yes ☐ No
Are there any medications your child should not be given or medication you would like us to contact you about before administering? _____
_____
Does your child take anything to help them sleep? If yes, be sure to bring enough mediation for the week.
☐ Yes ☐ No

Continued on next page

Camp Activities:
Are there any activities your camper should not participate in? ☐ Yes ☐ No
If yes, please list: _____
_____

Swimming:
Can your camper swim independently? ☐ Yes ☐ No
If no, please explain assistance needed. For example, water wings, personal flotation device, counselor assistance, etc. _____
_____

Camper Name: _____
Your Name: _____

Please note, by completing this form you are acknowledging that you are the parent/guardian or adult who is of close nature to the child and can verify the information provided above.