Camp Dogwood for the Blind & Visually Impaired
Medical Form
(To be filled out by a Physician or Physician's representative, i.e. PA or NP)

Camper's name:_____

Practice Name:_____
Practice address:_____
Physician's Printed Name:_____ Phone #:_____

Camp Dogwood is a recreational/vacation facility for persons with blindness or visual impairment. Campers have the opportunity, but are not required, to participate in activities such as tubing, boat riding, swimming, bowling, Putt Putt golf, shopping trips, crafts, and more. Campers must be able to provide their own personal care skills such as eating, bathing, dressing and toileting, or bring a caregiver to assist them with these needs. Campers ambulate from their dormitories to the dining hall/medication room up to a distance of 600 feet with a 12% grade in one direction. **NO SPECIAL DIETS ARE AVAILABLE AT CAMP.** Our counselor to camper ratio is 1 to 6. There is one nurse per 88 campers on site. The nurse is available to assist with routine medications and emergencies. **CAMP DOGWOOD IS NOT A NURSING OR CARE FACILITY.**

Medical History

☐ Yes ☐ No Does the patient have Diabetes?
If "Yes", controlled/stable?_____
☐ Yes ☐ No Does the patient have HIV?
☐ Yes ☐ No Has the patient had Hepatitis?
If "Yes" which type? _____
☐ Yes ☐ No Does the patient have Hearing Problems or Hearing Aids?
☐ Yes ☐ No Does the patient have Alzheimers, Dementia, or Senility?
If "Yes, which?_____
☐ Yes ☐ No Does the patient have a Developmental Disability?
If "Yes", which?_____
☐ Yes ☐ No Does the patient have a Mental Illness?
If "Yes", which?_____
☐ Yes ☐ No Does the patient have Hypertension/High Blood Pressure?
☐ Yes ☐ No Does the patient have a history of Kidney Disease?
If "Yes" What type?_____
☐ Yes ☐ No Does the patient require Dialysis Treatments?
If "Yes" list frequency._____
Dialysis patients must make arrangements for dialysis and dialysis transport before arriving at camp.

☐ Yes ☐ No Does the patient have Seizures?
If "YES" list frequency: _____

☐ Yes ☐ No Does the patient have known Drug or Food Allergies?
If "YES" to what? _____

☐ Yes ☐ No Does the patient have a history of Heart Failure, Heart Attacks, or Strokes?
Date of most recent episode._____

☐ Yes ☐ No Does the patient have Mobility Issues?
If "Yes" explain: _____

☐ Yes ☐ No Does the patient use Supplemental Oxygen?
If "Yes", patient is responsible for bringing all needed supplies.

☐ Yes ☐ No Does the patient use a CPAP machine?

☐ Yes ☐ No Is the patient a smoker?

☐ Yes ☐ No Does the patient sleepwalk? Frequency? _____

☐ Yes ☐ No The patient's medical status is stable and controlled. In my opinion this patient is able to attend the facility described above.

☐ Yes ☐ No The patient is their own legal guardian, and is able to make their own medical care decisions.
If you answer no, please list the Legal Guardian's name:
_____

Please list any other medical conditions you have. (Please Print): _____
_____
_____
_____
_____

Physician's Signature:_____Date:_____

Please return this form to the patient, or submit it directly to Camp Dogwood:

Mail: Camp Dogwood for the Blind & Visually Impaired
Attn: Camp Office
7050 Camp Dogwood Drive
Sherrills Ford, NC 28673
Fax: 828-478-4419
E-mail: Keisha@NCLionsInc.org

Please feel free to contact us with questions.
1-800-662-7401 x230

NOTE:

If you need assistance from the nurse with your medications you must bring them in the labeled prescription bottle/package. She/he will be unable to assist you unless they are in the proper container.

List Current Prescription Medications: (or attach separate sheet if necessary)

Medication & Strength	Dosage, Route, & Frequency

List PRN (as needed) Medications: (or attach separate sheet if necessary)

Medication & Strength	Dose, Route, & Frequency	PRN	Reason