

**Camp Dogwood for the Blind & Visually Impaired
Medical Form 2019**

(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 Does the patient have any reason they should **NOT** swim in the lake?
- 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
PO Box 39
Sherrills Ford, NC 28673

Fax: 828-478-4419

E-mail: [Dianne @NCLionsInc.org](mailto:Dianne@NCLionsInc.org)

Please feel free to contact us with questions.
828-478-2135