



**Camp Dogwood for the Blind and Visually Impaired
Medical History Form**

To be completed by physician or the physician's agent only

Camp Dogwood is a recreational/vacation facility for persons with blindness or visual impairment. Campers have the opportunity to participate in activities such as tubing, boat riding, swimming, bowling, Putt Putt golf, shopping, 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 and/or 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 emergencies. (Recurring dressing changes are not included)

CAMP DOGWOOD IS NOT A NURSING OR CARE FACILITY

Camper's Name _____

Date of Birth _____

Known Drug and/or food allergies										
CARDIOVASCULAR HISTORY					Date Dx'd Last on Avg BP Avg Bl Sugar	PULMINARY HISTROY				
Bleeding Disorder	Yes		No			Asthma	Yes		No	
CHF	Yes		No			COPD	Yes		no	
Heart Attack	Yes		No			Emphysema	Yes		No	
Hypertension	Yes		No			Oxygen dependent	Yes		No	
Pacemaker	Yes		No			RENAL DISEASE HISTORY				
COMMUNICABLE DISEASE HISTORY						Dialysis	Yes		No	
Hepatitis A, B, C	Yes		No			Kidney Disease	Yes		No	
If yes, specify type A, B, or C										
HIV	Yes		No			GENERAL HEALTH ISSUES				
DIABETES HISTORY					Hearing problems	Yes		No		
Stable	Yes		No		Hearing aids	Yes		No		
Hypoglycemia	Yes		No		Mobility Issues	Yes		No		
Insulin dependent	Yes		No		Devices used					
NEUROLOGICAL HISTORY					Sleepwalk	Yes		No		
Seizures					Use CPAP machine	Yes		No		
Date of last Seizure	Yes		No		<p align="center">*****Campers must bring all mobility devices, CPAP, and all oxygen equipment*****</p> <p align="center">Is Patient a Smoker? Yes No</p>					
Alzheimer's/Dementia	Yes		No							
Anxiety/Panic Disorder	Yes		No							
CVA/TIA	Yes		No							
Developmental Disability	Yes		No							
Dizziness/Fainting	Yes		No							
Mental Illness	Yes		No							
Parkinson's Disease	Yes		No							
~ IMPRTANT: MEDICATIONS										
Please attach a legible list of Current medications with complete instructions										

~ IMPRTANT: MEDICATIONS

Please attach a legible list of **Current** medications with complete instructions

Additional Recommendations from physician _____

Any reason camper should not swim in lake Yes No

If yes, explain

Camper may participate in high cardio activities (ie: water tubing, kayaking)

This patient's medical status is stable and controlled. In my opinion this patient is able to attend the facility described above

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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This patient is their own legal guardian, and is able to make their own medical care decisions.

If "no" list the Legal Guardian's name _____

Date of last Tetanus shot _____

Date of last medical exam _____

Date of Covid Vaccines _____

Physician's Signature _____ Date _____

Practice Name: _____

Address: _____

Phone _____ Fax: _____

Mail: Camp Dogwood for the Blind & Visually Impaired
Attn: Camp Office
PO Box 39
Sherrills Ford, NC 28673

Fax: 828-478-4419

E-Mail tammy@NCLionsInc.org

Please feel free to contact us with questions: 828-478-2135 ext 229

