Office Use Only: Rec'd On-___________
Approved by: ___________

2025 Camp Dogwood
Medical History and Current Medication update

Camper Name: ____
Date of Birth: ____

Known food or drug allergies: ________________________________
____

Medical form CAN NOT be completed before March 10, 2025!!

Circle one: Sighted Visually Impaired Legally Blind Newly Blind

(Circle the correct response)

1. Can patient walk distances of up to 600 feet with a 12% grade? YES NO
   If NO explain____________________________
   ____

2. Have you been hospitalized in the last 3 months? YES NO
   If yes, explain___________________________
   ____
   ____
   ____
   ____

3. Does patient have a history of neurological Disorders? YES NO

   Seizures YES NO
   Date of last seizure? ____________

   Alzheimer's/Dementia YES NO

   Anxiety/Panic Disorder YES NO

   CVA/TIA YES NO

When was the last episode? ____________________

Developmental Disability	YES	NO
DIZZINESS/ FAINTING	YES	NO
MENTAL ILLNESS	YES	NO

____
____
____
____

---

4. Communicable Disease History

Hepatitis?	YES	NO
Circle which type A- B- C		
HIV	YES	NO

5. Are you a diabetic?

Are you a diabetic?	YES	NO
Stable?	YES	NO
AVG. Blood Sugar___________		
Hypoglycemia /hyperglycemia	YES	NO
Frequency of episodes________________________		

If insulin dependent must provide a sliding scale.

____
____
____
____
____

6. Renal Disease History

Kidney Disease	YES	NO
What stage? _______________________		
Dialysis	YES	NO
Will you be receiving dialysis while at camp?	YES	NO

If yes, how often? Days Scheduled, Location and Transportation?
Peritoneal/ hemo dialysis
Graft/fistula/perm-cath

North Carolina Lions Camp Dogwood

____
____
____
____

7. Pulmonary History YES NO

Asthma YES NO

COPD YES NO

Emphysema YES NO

Oxygen dependent YES NO

Cpap at night YES NO

8. Does the patient have a cardio vascular history? Yes No

Bleeding Disorder

CHF

When diagnosed? ____________________

Heart Attack

When was last attack? ____________________

Hypertension

What is average pressure? __________________

Pacemaker

When was it placed? ______________________

Taking Blood Thinners?? YES NO

If yes – what medication?_____________________________

____
____

9. General Health
Hearing problems YES NO

Hearing Aids YES NO
Mobility Issues (other than white mobility cane) YES NO
Which device is used?____

___

___

Sleep Walk YES NO
Uses CPAP YES NO

10. Any medical reason(other than because they are blind) patient cannot swim in the lake? YES NO

11. Any reason why patient can not participate in high Cardio activities? YES NO

12. Is the patient their own legal guardian, if so are they able to make their own medical decisions? YES NO

13. It is essential that the patient be capable of managing their personal care and demonstrate life skills such as eating, bathing, dressing and toileting. In your opinion is the patient Capable of the skills listed? YES NO

14. Is patient able to administer their own medication and glucose testing? If yes, list medication and day injection is to be given. _________ YES NO

15. Does the patient take daily or weekly injections? YES NO

16. Date of last Tetanus Vaccine? ______________

17. Date of last medical exam? __________________

18. Are you on any medication now? YES NO

If, yes make sure the camp office
has a complete list. Include dose and any dosing instructions.

***You may be asked to provide additional documentation/information based on the above information given before approval of your camp application from the Camp Director is given. ***

Questions contact
828-478-2135 ext. 230 Camp Office
828-478-2135 ext. 229 Camp Director

Return form to:

NCLF
Camp Dogwood
PO Box 39, Sherrills Ford NC 28673

Phone 828-478-2135
Ext. 230 for questions and info.

FAX: 828-478-4419

By signing below, you certify that the information given on this form is correct to the best of your knowledge.

Print Physician Name: ____

Physicians Signature: ____

Practice Name: ____

Address: ______________________________

Phone: ____

Fax: ____