

Leadership Cardiology and Medical Form



To be filled out by applicant

{All medical information will be kept confidential with access to Medical Staff only}

APPLICANT'S NAME: _____ Birth Date: ____ / ____ / ____

Doctor's Name: _____ Phone: _____

Person(s) to be contacted in the case of emergency:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Name of Insurance Company: _____

Address: _____

Phone: _____ Group Number: _____ ID Number: _____

MEDICAL INFORMATION: (To be filled out by applicant)

IMPORTANT: Please inform us if you have been exposed to any communicable disease (chicken pox, measles, mumps) 1 – 3 weeks before camp.

HEALTH HISTORY: (If applicable, give approximate dates)

NOTE: If you are or have recently undergone treatment, use Cardiology form for more detailed medical information.

Asthma: _____ Ear Infections: _____ Hay Fever: _____

Bleeding Disorder: _____ Eczema: _____ Headaches: _____

Fainting Spells: _____ Hepatitis: _____ Cancer: _____

Seizures: _____ Chicken Pox: _____ German Measles: _____

Sinus Infections: _____ Measles: _____ Stomach Aches: _____

Diabetes: _____ Heart Defect: _____ Mumps: _____

Splenectomy: _____ Neuromuscular Disease: _____ Poison Ivy: _____

IMMUNIZATION HISTORY:

Tetanus Booster: _____ / _____ / _____

TB Test or Chest X-Ray: _____ / _____ / _____

Polio Series: _____ / _____ / _____

DBT Series: _____ / _____ / _____

Measles: _____ / _____ / _____

Mumps: _____ / _____ / _____

Do you have an allergy to any medications, foods, or other agents? (i.e., insect stings, penicillin, etc.)

Dietary restrictions and/or special food necessary:

List any restrictions or limitations:

Describe any recent injuries or surgeries:

Have you been hospitalized in the past two years? If yes, why?

CARDIAC / MEDICAL DIAGNOSIS

PLEASE print or type. Medical staff must be able to CLEARLY read the diagnosis.
(You may include a dictated note if helpful.)

<u>Cardiac Diagnosis</u>	<u>Surgical Intervention / Procedures Performed</u>	<u>Date Performed</u>

PRESCRIBED MEDICATION:

(Please be specific)

<u>Type of Medication</u>	<u>Dosage</u>	<u>Frequency</u>

PLEASE NOTE ADDITIONAL MEDICAL CONCERNS

Recommended Sub - Acute Bacterial Endocarditis Prophylaxis
✓ Check off item

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Standard Amoxicillin Regimen | <input type="checkbox"/> Other: _____ |

CARDIAC RHYTHM / DEVICE HISTORY

Does applicant have a history of dysrhythmia? Yes No Please describe: _____

Date of last episode: _____

Has there been any recent cardiac concern / medical event? _____

Does applicant have a PACEMAKER or ICD? Yes No

Reason for implantable device: _____

Date of insertion: _____

PACEMAKER

Brand: _____ Model: _____ Date of Last Interrogation: ____/____/____

Programmed To: _____ Mode: _____ Lower rate: _____ Upper Rate: _____

ICD

Brand: _____ Model: _____ Date of Last Interrogation: ____/____/____

Has ICD discharged recently? Y or N Date of Discharge: ____/____/____

How Often? _____

PLEASE LIST LAST PROGRAMMED SETTINGS FROM ALL DEVICES

I hereby authorize release of the information requested on this form to Camp del Corazon, it's delegates and other medical care providers that they deem appropriate and necessary.

Camper: _____ Signature: _____

Parent/Guardian Signature: _____ Date: _____

(Only if participant is under 18 years of age)