CATHOLIC CHARITIES
Diocese of Cleveland

812 BIRUTA STREET AKRON, OHIO 44307
PHONE (330) 762-2961 FAX (330) 762-2001
WWW.CAMPCHRIS.ORG

MEDICAL HISTORY AND INFORMATION

All information on this page must be completed to secure your Member's registration with Camp Christopher.

Member's Name: _____

Member's age: _____ Member's weight: _____ Member's height:_____

This document must be signed by a physician for your Member to receive medications at Camp Christopher.

Instructions given by physician, guardian and prescription bottle MUST MATCH IDENTICALLY. This form must be completed each time any medication is added, changed or deleted.

Drug Name	Strength	Dosage/ Route	Frequency	Time of Day	Taken at Camp?
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No
					Yes No

Does Member have a feeding tube?	Yes No
Please describe feeding/ administration instructions for feeding tube, including times and frequency.	
Does Member require medications immediately after a seizure? Please list medications and details on administration.	

legal guardian's initials: ☐

NAME OF MEMBER: _____

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PHYSICIAN MUST COMPLETE THIS SECTION

The following medications have side effects listed here, which require contacting a physician:
Please attach additional pages if necessary.

Medication	Contact physician if the following occurs:

The following medications have special instructions regarding administration:
(examples: take with food, take only with water)

Medication	Special instructions:

I have found this member to be without physical problems that would prohibit him/her from attending the programs of Catholic Charities. His/her general health is adequate to participate with respect to listed restrictions. I have reviewed the member's health and social histories and discussed the program with the guardian(s) of the member. I have provided up to date and accurate medical information on this form, including up to date prescription information. It is in my opinion that this member is fit to participate in the activities of Catholic Charities.

Physician's signature: _____ **Date:** ___/___/_____

Physician's name (typed or printed)**:** _____

Physician's phone: (_____) _____- _____

Physician's Availability: _____ AM PM **to** _____ AM PM

Please circle: Sun Mon Tues Wed Thurs Fri Sat

Physician's Office address: _____
Street *City* *State* *Zip*

legal guardian's initials: ☐