



2010 YOUTH RALLY CAMPER APPLICATION
XAVIER UNIVERSITY, CINCINNATI, OHIO
Monday, July 12 through Saturday, July 17
For Youths 11 – 17 years of age

YRC Application Part 2 • Youth Rally Health Form

To be completed by parent or guardian

Youth last name: _____ Youth first name: _____

Gender: M F Height: ____ Feet ____ Inches Weight: _____ Pounds

HEALTH HISTORY

The intent of this information is to provide camp health care personnel with sufficient background in order to provide appropriate care. Keep a copy of the completed form for your records. Any changes to the camper's health status as reflected on this form should be provided to camp health personnel upon camper's arrival at camp. Provide complete information so that the camp can be aware of all your child's needs.

ALLERGIES (please check all that apply) check here if camper carries an EpiPen none

Medication allergy/sensitivity (Check any that apply)

- Penicillin
- Sulfa
- Aspirin
- Other _____
- Ibuprofen/Advil/Motrin/Aleve/Naproxen
- Tylenol/acetaminophen
- Antibiotics

Describe reaction for any medication checked, and describe management of the reaction

Food allergy/sensitivity (Check any that apply)

- Milk/Dairy products
- Eggs
- Peanuts
- Fish
- Soy
- Wheat/gluten
- Bananas
- Other _____

Describe reaction for any foods checked, and describe management of the reaction

- Latex
- Cleaning Products
- Animals and/or animal dander
- Insect bites
- Feathers
- Skin care products (including sun-screen)
- Other _____

Describe reaction for any checked, and describe management of the reaction

DIETARY – Describe camper’s dietary needs related to bowel or urinary system and/or underlying illness.

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely at present. Bring enough medication to last the entire camp. Keep it in the **original packaging/bottle** that identifies the name of the medication, the dosage, the frequency of administration and the prescribing physician (if a prescription drug). If medications and/or schedule of dosage change by the time of Rally, please send new information with the camper.

- This person takes **NO** medications on a routine basis
- Yes No This person takes AN INJECTABLE MEDICATION
- Yes No This person takes medication for psychological disorder. (e.g.: mood, depression etc.)
- Yes No This person is independent with medication administration. *(Please note that if you check yes on the last one, our nurses and counselors will do their best to remind your camper to take their medications, but you are indicating that the child is responsible enough to take them as prescribed without such prompting.)*

Name of medication	Reason for giving	Dosage	Times to be taken

General Questions: Has the camper... /Does the camper ...:

	YES		YES
1. had any recent injury, illness or infectious disease?	<input type="checkbox"/>	15. have problems with joints? (e.g., knees, ankles)?	<input type="checkbox"/>
2. have a chronic or recurring illness/condition?	<input type="checkbox"/>	16. have an orthodontic appliance (being brought to camp)?	<input type="checkbox"/>
3. been hospitalized within the last year?	<input type="checkbox"/>	17. have any skin problems? (itching, rash, acne)	<input type="checkbox"/>
4. had surgery?	<input type="checkbox"/>	18. have diabetes?	<input type="checkbox"/>
5. have frequent headaches?	<input type="checkbox"/>	19. have asthma?	<input type="checkbox"/>
6. ever had a head injury?	<input type="checkbox"/>	20. have problems with sleepwalking?	<input type="checkbox"/>
7. ever been knocked unconscious?	<input type="checkbox"/>	21. if female, have abnormal menstrual history?	<input type="checkbox"/>
8. wear glasses or contacts?	<input type="checkbox"/>	22. ever had an eating disorder?	<input type="checkbox"/>
9. have frequent ear infections?	<input type="checkbox"/>	23. have a history of bed-wetting?	<input type="checkbox"/>
10. ever passed out during exercise?	<input type="checkbox"/>	24. have problems with diarrhea/constipation?	<input type="checkbox"/>
11. ever been dizzy during or after exercise?	<input type="checkbox"/>	25. ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>
12. ever had seizures?	<input type="checkbox"/>	26. ever been diagnosed with heart murmur?	<input type="checkbox"/>
13. ever had chest pain during or after exercise?	<input type="checkbox"/>	27. have back problems?	<input type="checkbox"/>
14. have high blood pressure?	<input type="checkbox"/>		<input type="checkbox"/>

Please explain any "yes" answers, noting the number of the question.

SELF CARE SKILLS	Independent	Needs help
1. Emptying pouch	<input type="checkbox"/>	<input type="checkbox"/>
2. Changing pouch	<input type="checkbox"/>	<input type="checkbox"/>
3. Toileting	<input type="checkbox"/>	<input type="checkbox"/>
4. Dressing	<input type="checkbox"/>	<input type="checkbox"/>
5. Bathing	<input type="checkbox"/>	<input type="checkbox"/>
6. Eating	<input type="checkbox"/>	<input type="checkbox"/>
7. Taking Meds	<input type="checkbox"/>	<input type="checkbox"/>
8. Other	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "needs help" answers, noting the number of the question.

My child's bowel or urinary diagnosis or dysfunction is:

- | | |
|--|--|
| <input type="checkbox"/> Ano-Rectal Malformation | <input type="checkbox"/> Chronic Bowel Obstruction |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Alagille & Byler's Syndrome |
| <input type="checkbox"/> Cloacal Exstrophy | <input type="checkbox"/> Post Urethral Valves |
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> GI Dysmotility |
| <input type="checkbox"/> Bladder Exstrophy | <input type="checkbox"/> Short Bowel Syndrome |
| <input type="checkbox"/> Hirschsprung's Disease | <input type="checkbox"/> Polyposis Syndrome |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Duplicate Renal System |
| <input type="checkbox"/> Neurogenic Bowel | <input type="checkbox"/> Neurofibromatosis |
| <input type="checkbox"/> Neurogenic Bladder | <input type="checkbox"/> Bowel transplant |
| <input type="checkbox"/> Other _____ | |

Has your child ever had surgery for bowel management? Yes No

Has your child ever had surgery for urinary management? Yes No

If yes for either, please list surgeries and approximate dates (in sequence if possible). We encourage you to send in any additional materials from your personal files or your teen's medical record, to help us understand and assist your teen as much as possible.

Name of surgery	Date	Result

Please check your child's current bowel and/or urinary management process (all that apply).

- | | |
|---|--|
| <input type="checkbox"/> Ileostomy | <input type="checkbox"/> Incontinent of urine |
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Incontinent of stool |
| <input type="checkbox"/> Urostomy | <input type="checkbox"/> Bowel Management Program |
| <input type="checkbox"/> No ostomy | <input type="checkbox"/> Continent Diversion - bowel |
| <input type="checkbox"/> Self-Catheterization | <input type="checkbox"/> Continent diversion – urinary |
| <input type="checkbox"/> Mitrofanoff | <input type="checkbox"/> Diapers/Depends |
| <input type="checkbox"/> Unknown (please provide details) _____ | |

Specify the help your child will need at camp with bowel and/or bladder management.

- Teaching/discussing effective stoma management techniques
- Advice on appropriate pouching system
- Measuring and pre-cutting barrier opening
- Changing pouch system
- Teaching/discussing effective bowel management techniques
- Setting up bowel management supplies
- Assisting with bowel management activity

- Teaching/discussing effective urinary management techniques
- Setting up urinary management supplies
- Assisting with urinary management activity
- Other – *explain here, or provide details of selected items above:*

Use of mobility aids:

- | | | |
|---|---|--|
| <input type="checkbox"/> Uses wheelchair..... | <input type="checkbox"/> Can Transfer
<input type="checkbox"/> Cannot Transfer | <input type="checkbox"/> Uses forearm crutches, cane or crutches |
| <input type="checkbox"/> Uses walker | | <input type="checkbox"/> Uses orthotic _____ |
| <input type="checkbox"/> Uses prosthetic limb _____ | | |

Other impairments:

- | | |
|---|---|
| <input type="checkbox"/> Visually Impaired (uncorrected by glasses) | <input type="checkbox"/> Psychological/Emotional concerns |
| <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Uses Total Parenteral Nutrition |
| <input type="checkbox"/> Mental Disability/ Developmental Delay | <input type="checkbox"/> Uses IV fluids |
| <input type="checkbox"/> Other medical needs _____ | |

Use the space below to provide any additional information about the participant’s behavior and physical, emotional, or mental health, which the camp should be aware. *(Examples: has periods of depression/sadness, needs to be reminded to take medication, treatments not mentioned, etc. -- Attach separate sheet if necessary.)*

Are there any special things you would like your child to learn or accomplish at camp?

Please explain any special concerns that you would like the staff to address while your child is at camp.