CATHOLIC CHARITIES
Camp I Am Special

2024 Physician Statement for Catholic Charities Camp I Am Special

All Physician Statements require the Physician's contact information, and *must* be uploaded to the Participant's account. Keep original for your records.

PARTICIPANT'S Name: _____ **Date of Birth:** _____

Parent's/Guardian's Name: _____ **Doctor's Name:**_____

Medical Diagnoses:

Primary:_____

Secondary:_____

Allergies: _____ ☐ No known allergies

Is this person capable of participating in this camp?

Physically? Yes ___ No ____ Limitations:_____
Mentally? Yes ___ No ____ Limitations:_____

Diet/Nutrition: ☐Eats a regular diet
☐Has a medically prescribed meal plan or dietary restrictions as described here:
_____.

Treatments needed while at Camp: (mark all those that apply)

___ Catheter	___ Enema	___ Inspire	___ Shunt
___ CPAP	___ Epi pen	___ Nebulizer	___ VNS Stimulator
___ Diastat	___ Feeding Tube	___ Oxygen	___ Other: _____

If participant needs any Medical Treatments or Procedures while at camp, the *Medical Treatment and Procedure Protocol Form* needs to be completed by the parent. One form for each treatment.

Physician's Signature: _____Date: _____

Physician Group Practice Name:_____Phone Number:_____

Physician Address: _____

If our Camp Office has questions or concerns, who would we contact to verify this information:

Name of Contact: _____

Contact number: _____ Contact email: _____

Catholic Charities Camp I Am Special

235 Marywood Drive * St. Johns, Florida * 32259 * 904.230.7447 -Email: campiamspecial@ccbjax.org

Upload to Campers or Buddies Ultra Camp Account