This evaluation must take place in the twelve months prior to the camp session.

Volunteer's Name:_____ **Age:** _____
Vital Signs: Height:_____ **Weight:** _____ **Pulse:**_____
Resp. Rate (resting):_____ **Blood Pressure (Resting, Sitting):** _____
General Inspection:_____

	Status, Essential Findings, Deviating from Normal
Head	
Eyes/Vision	
Nose	
Mouth/Teeth	
Ears/Hearing	
Neck/Thyroid	
Thorax/Lungs	
Heart	
Abdomen/Hernia	
Skin	
Lymphatics	
Spine	
Extremities	
Emotional Status	

Please fill out if volunteer is diagnosed with Epilepsy:

Seizure Classification: Type #1:_____ **Type #2:** _____
Current anti-epileptic therapy: _____ **Medication** _____ **Vagus Nerve Stimulator** _____ **Ketogenic Diet**

List all medications currently taking.

Medications	Strength	Frequency	Notes

NOTE TO HEALTH PROVIDER:

1. **The above named person wishes to participate as a volunteer at the Epilepsy Foundation Texas' Summer Camp. Participation involves group lining and activities in an outdoor setting, a high level of physical activity, swimming and attending to needs of individuals living with epilepsy.**
   In your medical opinion, is Epilepsy Foundation Texas Summer Camp an appropriate environment for this individual?
   (CHOOSE ONE) YES NO
2. **I have examined the person herein described and have reviewed his/her health history.**
   Is it your opinion that the application is medically, physically and emotionally able to participate as a volunteer at the Epilepsy Foundation Texas Summer Camp, which includes a high level of physical activity?
   (CHOOSE ONE) YES NO
   If no, please explain: _____
   _____
   _____

A PHYSICIAN/HEALTH PROFESSIONAL MUST SIGN IN THE SPACE PROVIDED BELOW:

_____ Print Physician/Medical Professional's Name

_____ Physician/Medical Professional's Signature

_____ Date

_____ Address

_____ City

_____ Phone Number