Malta Camp USA
JUNE 20 - 26, 2026 AT SIENA COLLEGE

EVALUATION OF MEDICAL CONDITION AND MEDICAL/NURSING CARE REQUIREMENTS OF PROSPECTIVE PARTICIPANT WITH DISABILITY

IT IS NECESSARY TO ANSWER **ALL** QUESTIONS

REMINDER: FOR APPLICANTS SEEING A PSYCHIATRIST AND/OR TAKING PSYCHOACTIVE MEDICATIONS, THIS FORM MUST BE FILLED OUT BY **BOTH** THE APPLICANT'S PCP AND THEIR PSYCHOACTIVE PRESCRIBING PHYSICIAN

GENERAL GUEST INFORMATION:

Name: _____ Date of Birth: _____

Address: _____

City: _____ ST: _____ Zip: _____

Preferred Phone Number: _____ Email Address: _____

Physician's Evaluation

Please return this form via email to info@maltacampusa.org or via fax to 212-486-9427

For this patient to be considered for the Malta Camp USA, all questions must be answered and signed off by his/her physician, physician's assistant, or nurse practitioner.

1. Primary disability: _____

_____

_____

2. Other relevant medical diagnoses: _____

_____

_____

_____

3. Prior surgeries: _____

_____

_____

4. Have there been any hospitalizations in the past 6 months? If yes, please provide a very brief explanation of the reason for the admission? _____

_____

_____

5. Are there any planned procedures or hospitalizations planned in the next 6 months? If so, what procedure or for what reason?_____

_____

6. Malta Camp USA is a week-long sleepaway camp based in New York state. Each day we participate in activities such as dances, crafts, adventure activities (e.g., river rafting, ziplining), and other excursions (e.g., bowling, water park). Camp days are busy and generally run from 8am to 10pm with few breaks. During camp, medical staff are on-site to assist with any urgent needs and medication administration.

Do you have any concerns about the patient's ability to participate in camp? ❑ Yes ❑ No

If yes, please explain: _____

_____

7. Will this patient require the use of any special devices while at camp, for example mobility aid, CPAP?
❑ Yes ❑ No

If yes, please explain: _____

_____

_____

8. How often do you see this patient? _____

9. Is the patient currently undergoing any treatment for his/her disability? ❑ Yes ❑ No
If yes, what is the nature of the treatment and do you expect to complete it in the near future? If so, when? _____

_____

_____

10. How would you describe the patient's ability to cope with their disability (mentally, as well as physically). Does the patient engage in any self-soothing behaviors (e.g., physical or verbal stimming)? If so, please describe.

_____

_____

_____

11. Medications: Please list all medications (both regularly taken and user prn (e.g., inhaler) of patient, including dosages and schedule

Medication	Dosage	Schedule

12. Please list all known allergies to medications and foods:

_____

_____

13. Does the patient have a history of mental health diagnoses that our selection committee should be aware of? Have they ever been considered a risk to others or to themselves?

_____

_____

_____

14. Does the patient have a history of incontinence? If so, please describe the nature, frequency, and any known triggers.

_____

_____

15. To the best of your knowledge, does the patient have a history of aggressive or inappropriate behaviors? If so, what treatments or mitigations have been implemented and with what results?

_____

_____

_____

16. Please provide any additional comments or information that would be helpful for the selection committee: _____

_____

_____

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_____

_____

_____

Physical Exam & Review of Systems

Height: _____ Weight: _____ Blood Pressure _____

Diagnosis: _____

_____

_____

Specific Medical Care Requirements: _____

_____

1. Cardiovascular: Problem: ❑ Yes ❑ No

If yes, specify:

❑ Chest Pain

❑ Palpitations

❑ Shortness of Breath

❑ Swelling of lower extremities

❑ Blood Pressure

❑ Other: _____

❑ Stroke

Comments: _____

_____

2. Respiratory: Problem: ❑ Yes ❑ No

If yes, specify:

❑ Cough

❑ Abnormal sputum

❑ Shortness of Breath

❑ Other: _____

Comments: _____

_____

3. Hearing: Problem: ❑ Yes ❑ No

If yes, describe: _____

Hearing Aid: ❑ Yes ❑ No

4. Vision: Problem: ❑ Yes ❑ No

If yes, describe: _____

5. Gastrointestinal: Problem: ❑ Yes ❑ No

If yes, specify:

❑ Pain ❑ Nausea ❑ Vomiting ❑ Ileostomy ❑ Colostomy

Comments: _____

_____

6. Bowel & Urinary: Problem: ❑ Yes ❑ No

Incontinence: ❑ Frequent ❑Occasional ❑Bedwetting

Comments: _____

Level of care: ❑ Self ❑ Physical Assistance

Specify: _____

7. Nutrition: Problem: ❑ Yes ❑ No

If yes, describe: _____

Level of nutritional care needed: _____

Special Diet: ❑ Yes ❑ No

If yes, specify: _____

Needs to be fed: ❑ Yes ❑ No

Comments: _____

8. Neuromuscular Problem: Check all applicable items:

❑ Ambulatory

❑ Ambulatory with limitation

❑ Non-ambulatory

❑ Amputation: ❑Yes ❑ No

If yes, describe: _____

Paralysis: ❑ Yes ❑ No If yes, describe: _____

Seizures: ❑ Yes ❑ No If yes, Type: _____ Frequency _____

Significant limitation of motion: ❑ Yes ❑ No If yes, describe: _____

_____

9. Hygiene/Grooming:

Level of care needed: _____

Bathing: ❑ Self ❑ Assistance - ❑Total ❑Partial

Dressing: ❑ Self ❑ Assistance - ❑Total ❑Partial

Hair: ❑ Self ❑ Assistance - ❑Total ❑Partial

General Comments: _____

_____

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IT IS NECESSARY TO ANSWER ALL THE QUESTIONS ABOVE

REMINDER: For this patient to be considered for Malta Camp USA, all questions **must** be signed off by his/her physician.

***APPLICATION CANNOT BE PROCESSED WITHOUT THE SIGNATURE OF A PHYSICIAN, PHYSICIAN'S ASSISTANT, OR NURSE PRACTITIONER**

Physician's Signature:* Date:

Print Physician's Name:

Physician's Address:

Office Number: Fax Number:

Email Address: