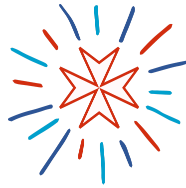

Malta Camp USA
JUNE 22-27, 2025 AT SIENA COLLEGE

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

IT IS NECESSARY TO ANSWER **ALL** QUESTIONS

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

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.

Do you have any concerns about the patient's ability to participate in camp? ❑ Yes ❑ No
If yes, please explain: ____

____

Will this patient require the use of any special devices while at camp, for example oxygen, electric wheelchair, CPAP?

❑ Yes ❑ No

If yes, please explain: ____

____

7. How often do you see this patient? ____

8. 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? ____

____

____

9. 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.

____

____

____

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

Medication	Dosage	Schedule

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

____

____

12. 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?

____

____

____

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

____

____

14. 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?

____

____

____

15. 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

❑ Non-ambulatory

❑ Ambulatory with limitation

❑ 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: ________________________________