CAMP HEALTH/PHYSICAL FORM - 2021

Please attach a copy of the camper's immunization records to this form

Last Name	First Name	M.I.	Age	D.O.B.	Gender
Parent or Guardian				Phone	
Home Address					
City		State		Zip	

If you are NOT available, in an emergency, notify (must be different than above):

Emergency Contact Name		
Phone Number (H)	(C)	(W)
Address		
City	State	Zip

PART 1: HEALTH CONCERNS (completed by parent/guardian):

*For emergency/life-threatening conditions, please also attach action plan from clinic and include emergency medication for nurse.

☐ Food sensitivities (list food & reaction): _____

☐ *Allergies (allergen, reaction, & manner - i.e.: if touched, ingested, or airborne): _____

☐ *Asthma (list triggers): _____

☐ *Diabetes (how it's managed - i.e.: oral meds, pump, injections): _____

☐ *Seizures (list triggers, description, and auras) _____

☐ Heart Condition: _____

☐ Recent injuries, surgeries, or hospitalizations: _____

☐ Activity restrictions: _____

☐ Implanted devices: _____

☐ Bowel/Bladder concerns: _____

☐ Emotional/Social/Behavioral concerns: _____

☐ If applicable, has this camper menstruated yet? (list special instructions): _____

☐ Other concern: _____

PART 2: PHYSICAL EXAMINATION (completed by licensed provider within 12 months of arrival at camp):

Date of last physical exam: _____ Height: _____ Weight: _____

Indicate Normal (N) or Abnormal (AB) -include comments below if AB

	N	AB		N	AB		N	AB		N	AB
Eyes			Genitourinary			Extremities			Neurological		
Ears			Gastrointestinal			Abdomen			Heart		
Nose			Feet			Skin			Lungs		
Throat			Spine			Endocrine			Lymph		

Comments:_____

Name of Provider (MD/DO/PA-C/NP): _____

Phone number: _____ Signature: _____

PART 3: MEDICATIONS (ALL medications must arrive at camp in original bottles with correct pharmacy label for prescriptions OR be pre-packaged/labeled by pharmacy):

Mark "yes" or "no" to give permission for the following medications provided by the camp (to be given only "as needed"):

Medication	Yes	No	Medication	Yes	No
Acetaminophen (Tylenol) for pain/fever			Loperamide (Imodium) for diarrhea (*not given if fever)		
Ibuprofen (Motrin, Advil) for pain/fever			Magnesium Hydroxide for constipation		
Diphenhydramine (Benadryl) for allergy			Hydrocortisone cream 1% for skin irritation		
Cetirizine (Zyrtec) for seasonal allergy			Triple Antibiotic cream for first aid		
Calcium Carbonate (Tums) for acid reflux			Aloe, Calamine, Sunscreen, Bugspray, Cough Drops		

Special instructions for medications (i.e., mix with applesauce): _____

List all prescription and (additional) non-prescription medication you request the camp nurse to administer. Please note- scheduled medication is preferred to be given during mealtimes at camp, however, if an alternate time is requested, please be specific. Mealtimes are generally scheduled for breakfast (8-9 a.m.); lunch (12-1 p.m.); dinner (5-6 p.m.); bedtime snack (8-9 p.m.).

Medication Name	Dose	Route	Meal to be given (or other time)	Reason/indication for PRN

Name of Prescriber (MD/DO/PA-C/NP) :_____

Phone number: _____ Signature: _____

I attest to the information provided and I acknowledge it is my responsibility to inform the camp of any changes. I give permission for the camp nurse to confidentially exchange health information for use in meeting the camper's health needs. I understand the camp nurse and designated staff will provide the camper with basic first aid treatment. In the event of an emergency, I hereby give permission to provide this camper with any further medical care deemed necessary by medical professionals selected by the camp. I furthermore, authorize the camp nurse and delegated staff to administer medication as indicated above.

Parent/Guardian Name: _____Signature: _____Date: _____