

2012 CAMPER PHYSICAL FORM

PHYSICIAN OR NURSE MUST SIGN AND DATE UPON SUBMISSION – UPDATED HEALTH PHYSICAL FORM IS REQUIRED FOR ATTENDANCE EACH YEAR

MEDICAL PERSONNEL: Please review the Camper Health History Form and complete the remaining sections of this form.
**Campers must have a physical within 24 months of their summer camp session.*

PARENT PORTION

*Attach additional information if needed.

| | | | | |
|---------------|-----------------|-------------------------|-----------------------|----------------------------------|
| CAMPER NAME | | GENDER: | SESSION(S) ATTENDING: | |
| HOME ADDRESS | | AGE ON ARRIVAL AT CAMP: | | DATE OF BIRTH: MM / DD / YEAR |
| PARENT 1 NAME | PARENT 1 CELL # | PARENT 1 WORK # | | |
| PARENT 2 NAME | PARENT 2 CELL # | PARENT 2 WORK # | | |

MEDICAL PERSONNEL PORTION

| | | | | |
|---|--|--------|--------|----------------|
| WAS A PHYSICAL EXAMINATION DONE TODAY? <input type="radio"/> YES <input type="radio"/> NO | IF "NO," PLEASE NOTE THE DATE OF THE LAST PHYSICAL: MM / DD / YEAR | WEIGHT | HEIGHT | BLOOD PRESSURE |
|---|--|--------|--------|----------------|

Session (s)

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an *as needed basis* to manage illness and injury.
Medical Personnel: Cross out any of the following items the camper should NOT be given:
 Acetaminophen (Tylenol), Ibuprofen (Advil, Motrin), Phenylephrine (Sudafed PE), Pseudoephedrine (Sudafed), Chlorpheniramine Maleate, Guaifenesin (Mucinex), Dextromethorphan (Robitussin DM), Diphenhydramine (Benadryl), Generic Cough Drops, Chloraseptic (Sore Throat Spray), Bismuth Subsalicylate (Pepto-Bismol), Topical Antibiotic Cream, Lice Shampoo or Scabies Cream (Nix or Elimite), Calamine Lotion, Hydrocortisone 1% Cream, Laxatives for Constipation (Ex-Lax), Aloe

Middle Name

| ALLERGIES | PLEASE NOTE & PROVIDE INFORMATION REGARDING PREVIOUS REACTIONS |
|--|--|
| <input type="radio"/> NO KNOWN ALLERGIES | |
| <input type="radio"/> TO FOODS | |
| <input type="radio"/> TO MEDICATIONS | |
| <input type="radio"/> TO THE ENVIRONMENT | |
| <input type="radio"/> OTHER ALLERGIES | |

First Name

| DIET & NUTRITION | PLEASE DESCRIBE |
|--|-----------------|
| <input type="radio"/> EATS A REGULAR DIET | |
| <input type="radio"/> HAS A MEDICALLY DESCRIBED MEAL PLAN OR DIETARY RESTRICTIONS: | |

| THE CAMPER IS CURRENTLY UNDERGOING TREATMENT FOR THE FOLLOWING CONDITIONS | PLEASE DESCRIBE |
|---|-----------------|
| <input type="radio"/> NO TREATMENT(S) | |
| <input type="radio"/> | |

| OTHER TREATMENTS/THERAPIES TO BE CONTINUED AT CAMP | PLEASE DESCRIBE |
|--|-----------------|
| <input type="radio"/> NO TREATMENT(S) | |
| <input type="radio"/> | |

| MEDICATION | MEDICATION | DOSAGE | FREQUENCY | REASON |
|--|------------|--------|-----------|--------|
| <input type="radio"/> NO DAILY MEDICATIONS | | | | |
| <input type="radio"/> WILL TAKE THE FOLLOWING PRESCRIBED MEDICATION(S) WHILE AT CAMP | | | | |

| DO YOU FEEL THE CAMPER WILL REQUIRE LIMITATIONS OR RESTRICTIONS TO ACTIVITY WHILE AT CAMP? | IF "YES," PLEASE DESCRIBE YOUR RECOMMENDATIONS DURING THE WEEKLONG SUMMER SESSION THE CAMPER PLANS TO ATTEND. |
|--|---|
| <input type="radio"/> NO | |
| <input type="radio"/> YES | |

Last Name

"I HAVE REVIEWED THE CAMPER HEALTH FORM AND DISCUSSED THE CAMP PROGRAM WITH THE CAMPER'S PARENTS(S)/GUARDIAN(S). IT IS MY OPINION THAT THE CAMPER IS PHYSICALLY AND EMOTIONALLY FIT TO PARTICIPATE IN AN ACTIVE CAMP PROGRAM."

(EXCEPT AS NOTED ABOVE)

| | | |
|--|-------------------------|-----------|
| NAME OF LICENSED PROVIDER (PLEASE PRINT) | SIGNATURE | DATE |
| OFFICE ADDRESS | CITY / STATE / ZIP CODE | TELEPHONE |