FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

PHANTOM LAKE YMCA CAMP
2017 PHYSICAL FORM
DUE DATE: MAY 15TH OR ASAP

office@phantomlakeymca.org
S110W30240 YMCA Camp Rd
Mukwonago, WI 53149

EVERY YEAR- A New Physical Form Is Required For Attendance
**Physical must have been within 24 months from the 1st day child is attending camp.

Last Name	First Name	Date of Birth:
Parent 1 Name	Parent 2 Name	Date Camper Starts Camp:

MEDICAL PERSONNEL PORTION

WAS THE PHYSICAL DONE TODAY? ☐ YES ☐ NO	IF "NO," DATE OF LAST PHYSICAL: DATE ______/______/______	Weight	Height	Blood Pressure

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 (Motrin), Pseudoephedrine (Sudafed), Dextromethorphan (Robitussin), Diphenhydramine (Benadryl), Loratadine (Claritin), Cough Drops, Topical Antibiotic Cream, Calamine Lotion, Hydrocortisone Cream, Laxatives (Milk of Magnesia), A&D Ointment, Antacid, Benzocaine Oral Gel, Epinephrine, Eye Wash, Lidocaine Spray, Oxygen, Powder (Gold Bond), Swimmer Ear-Drop

ALLERGIES	**PLEASE NOTE & PROVIDE INFORMATION REGARDING PREVIOUS REACTIONS**
☐ NO KNOWN ALLERGIES	
☐ TO FOODS	
☐ TO MEDICATIONS	
☐ OTHER ALLERGIES	

DIET & NUTRITION	
☐ EATS A REGULAR DIET	**PLEASE DESCRIBE**
☐ HAS A MEDICALLY DESCRIBED MEAL PLAN OR DIETARY RESTRICTIONS:	

THE CAMPER IS CURRENTLY UNDERGOING TREATMENT FOR THE FOLLOWING CONDITIONS	
Condition:	**PLEASE DESCRIBE**
☐ NO TREATMENT(S)	

OTHER TREATMENTS/THERAPIES TO BE CONTINUED AT CAMP	
treatments/therapies	**PLEASE DESCRIBE**
☐ NO TREATMENT(S)	

MEDICATION				
☐NO DAILY MEDICATIONS	MEDICATION	DOSAGE	FREQUENCY	REASON
☐ 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?	
☐ No	If "Yes," Please Describe your recommendations during the weeklong summer session the camper plans to attend.
☐ Yes	

Signature of Doctor or Nurse

"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 or nurse **(please print)**	**Signature**	**Date of signature** / /
Office Address	City / State / Zip Code	Telephone

PHYSICIAN OR NURSE MUST SIGN AND DATE UPON SUBMISSION