FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

2018 PHYSICAL FORM
PHANTOM LAKE YMCA CAMP
DUE DATE: MAY 15TH OR ASAP

office@phantomlakeymca.org
262.363.4386
S110W30240 YMCA Camp Rd
Mukwonago, WI 53149

AN UPDATED SIGNATURE IS REQUIRED EVERY YEAR!
PHYSICAL FORM IS REQUIRED FOR ATTENDANCE EACH YEAR
***Campers must have a physical within 24 months of their summer camp session.**
PARENTS PLEASE SCAN AND UPLOAD THIS FORM DIRECTLY TO YOUR CAMPER'S CAMP INTOUCH ACCOUNT

LAST NAME:	FIRST NAME	DATE OF BIRTH:

PARENT 1 NAME	PARENT 2 NAME	PHONE #

MEDICAL PERSONNEL PORTION

WAS A PHYSICAL EXAMINATION DONE TODAY? ☐ YES ☐ NO	IF "NO," DATE OF THE LAST PHYSICAL: ___/___/___	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

Session (s) Middle Name First Name Last Name