

CAMPER MEDICAL FORM

This form is to be completed by a licensed physician. Examination required within 12 months of camp.

Patient Information:

NAME (first/last): _____ GENDER: M F DOB: _____ AGE: _____
 PHONE: _____ DATE OF LAST EXAM: _____ PHYSICIAN: _____

Medical Information:

HT: _____ WT: _____ BP: _____
 Explain using code: *S Satisfactory* *NS Not Satisfactory*
 Eyes: _____ Ears: _____ Nose: _____ Throat: _____ Heart: _____ Lungs: _____ Abdomen: _____ Skin: _____ Extremities: _____

Abnormal Findings?: _____

Daily Medications to be continued at camp?: YES NO

If yes, please describe dose and frequency: _____

Is the patient under the care of a physician for any conditions?: YES NO

Do you feel the camper will require limitations or restrictions to activity while at camp? YES NO

Other treatments/therapies to be continued at camp?: YES NO

If "yes," please explain: _____

Patient Allergies:

No Known Allergies

To foods: _____ To Medications: _____

To the environment (insect stings, hay fever etc.): _____ Other: _____

Patient Diet:

Eats Regular Diet Has medically prescribed meal or dietary restrictions: _____

Other: _____

Non Prescription Medications: *Cross out the medications the camper **SHOULD NOT** be given.*

Tylenol	Calamine	Cough Syrup	Sudafed PE	Cough Drops	Pepto Bismol	Ex-Lax
Ibuprofen	Hydrocortisone	Scabies Cream	Aloe	Sudafed	Lice Shampoo	
Benadryl	Chloraseptic	Sucrets	Dextromethorphan	Guaifenesin	Topical Antibiotic	

Physician Authorization for Participation:

I have reviewed the camper's health history, and have discussed the camp program with the camper's parent(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).

PHYSICIAN SIGNATURE: _____ DATE: _____

PHYSICIAN NAME PRINTED: _____ PHONE NUMBER: _____