PLEASE HAVE THE HEALTH CARE PROVIDER COMPLETE PAGES 2, 3 and 4

Medical Evaluation

I examined ______________________________ (patient's name) _____________ (date of birth) on ____/____/____.

(American Camp Association accreditation requirements specify exams within 12 months of camp attendance. A new exam is not necessarily required for camp attendance.)

Screening/Test Results

Height:	BMI:	Vision/Type of Screening
Weight:	☐ Normal	With glasses R 20/ L 20/
Blood Pressure:	☐ Abnormal	Without glasses R 20/ L 20/
Pulse:	Min:	
HCT/Hgb:	Slight:	Auditory/Type of Screening
Urinalysis:	Mod:	Right Pass/Fail
Gross Dental:	Marked:	Left Pass/ Fail
Lead (Date/Result)	☐ Referral to:	

TB: In high risk group? ☐Yes ☐ No		
TB & other Test Results (sickle Cell, etc)		
Test	Date	Result

Disease Assessment

Yes No		Date of Onset
☐ ☐ Asthma	☐ Mild ☐ Moderate ☐ Severe ☐ Exercise Induced ☐ Unclassified	
☐ ☐ Diabetes	☐ Type I ☐ Type II	
☐ ☐ Anaphylactic Reaction	☐ Food ☐ Insect ☐ Latex ☐ Other: Explain	
☐ ☐ Seizure Disorder	Type:	
☐ ☐ Chicken Pox	If yes, when?	
☐ ☐ Mumps	If yes, when?	
☐ ☐ Other: Please Specify		

Emergency Medications:

Does this person require Epipen: ☐ YES ☐ NO PRN Inhaler: ☐ YES ☐ NO
This person has permission to carry: Epipen: ☐ YES ☐ NO PRN Inhaler: ☐ YES ☐ NO
(Note: ability to carry implies ability to self administer)

Additional Orders: (As deemed necessary by health care provider to be implemented by R.N. (i.e. peak flows, blood draws/lab work, dressing changes, cast care, feed via GT tube, etc):____

____

____

Limitations on Activities: Swimming ______ Diving _____ Hiking ______ Athletics ______Other____________________
Explain above:____

____

Individualized Orders for ___________________________________ Date completed _______________________

The following Standard "Over the Counter" PRN Medications are available in the Health Center to be administered per the family physician's instructions.

This page must be completed by the Physician. Please cross out any OTC medications not desired for this camper.

Drug Generic equivalents may be used	Route	Dosage	Schedule and Indications	Comments
Diphenhydramine	PO	As per pkg by wt and age	Allergies or Allergic Reactions	
Burn Gel	Topically	Apply to minor burns	Minor Burns	
Tums	PO	As per pkg by wt and age	No BM x 3 Days	
Acetaminophen	PO	As per pkg by wt and age	Temp. $\geq$ 100° or Pain	
Ibuprofen	PO	As per pkg by wt and age	Temp. $\geq$ 100° or Pain	
Hydrocortisone	Topically	Apply to effected area 3x /day	Itch	
Cough Drops	PO	As per pkg by wt and age	Cough or Sore Throat	
Triple Antibiotic	Topically	Apply to effected area 3x /day	Scrapes or Cuts	
Bacitracin	Topically	Apply to effected area 3x /day	Scrapes or Cuts	

Non Prescription and Prescription Medications (Please complete with patient's current regimen for both scheduled and prn medications. Use 2nd page if needed) this includes vitamins, inhalers, ear and eye drops. ***Medications must be in the original labeled bottle with directions for administration.***

Drug	Route	Dosage	Schedule and Indications	Comments

Please Record Immunization Dates on Page 4. A copy of a current immunization record is acceptable.

I certify that I have on this date examined the above named camper and that on the basis of my examination and the medical history as furnished to me, I have found no reason which would make it medically inadvisable for this camper to participate in physically strenuous activities.

Signature of Physician ____ Date of Examination ________________

Please Print: Physician's Name _____________________________________ License # __________________________

Address____ Phone # ___________________________

Camper Name ___________________________ **Week Attending**___________________

Immunization History

(**Please Provide Month, Day and Year of Immunization**) Or attach a copy of physician report of immunizations.

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DPT/Hib						
DTaP						
DT/Td						
OPV						
IPV						
MMR						
HiB						
Hep B						
Hep A						
Varicella						
TDap						
PCV						
HPV						
MCV						
Influenza:						

HIPPA Privacy Statement: Permission to Release Confidential Information **Parents please complete!!!**

I give ____ permission to release confidential health information to
(Name of Medical Practice) Holmes Presbyterian Camp and Conference Center regarding this person.

Date:_____________________ Parent/Guardian Signature____

For Camp Use Only

Screening checklist completed _____time ____ am/pm Updates/additions to health history noted? ___ YES ___ NO

Meds received ___________________________ Current Health needs identified ______________________________

_______________________________________ Screened by ____

Camper Name ___________________________ **Week Attending**___________________