

## Medical Evaluation

Camper Name \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ has had a complete history & physical exam on \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Height:	BMI:	Vision/Type of Screening
Weight:	<input type="checkbox"/> Normal	With glasses R 20/ L 20/
Blood Pressure:	<input type="checkbox"/> Abnormal	Without glasses R 20/ L 20/
Pulse:		
HCT/Hgb:	TB: In high risk group? <input type="checkbox"/> Yes <input type="checkbox"/> No	Auditory/Type of Screening
Urinalysis:	TB & other Test Results (sickle Cell, etc)	Right Pass/Fail
Gross Dental:		Left Pass/ Fail
Lead (Date/Result)		

Yes No	To What:	Date of Onset
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Exercise Induced <input type="checkbox"/> Unclassified	
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> Type I <input type="checkbox"/> Type II	
<input type="checkbox"/> <input type="checkbox"/> Anaphylactic Reaction	<input type="checkbox"/> Food <input type="checkbox"/> Insect <input type="checkbox"/> Latex <input type="checkbox"/> Other: Explain	
<input type="checkbox"/> <input type="checkbox"/> Seizure Disorder	Type:	
<input type="checkbox"/> <input type="checkbox"/> Chicken Pox	If yes, when?	
<input type="checkbox"/> <input type="checkbox"/> Mumps	If yes, when?	
<input type="checkbox"/> <input type="checkbox"/> Other: Please Specify		

DPT/Hib					
DTaP					
DT/Td					
OPV					
IPV					
MMR					
Hib					
Hep B					
Hep A					
Varicella					
TDap					
PCV					
HPV					
MCV					
Influenza					

**Please Record Immunization Dates on Page 3. A copy of a current immunization record is acceptable.**

Camper Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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	Indications	Comments
Diphenhydramine	PO	___MG ___ML	Q_____HRS	Insect Bites, Allergies	
Tums	PO	___MG ___ML	Q_____HRS	Indigestion	
Acetaminophen	PO	___MG ___ML	Q_____HRS	Pain, Fever	
Ibuprofen	PO	___MG ___ML	Q_____HRS	Pain, fever	
Hydrocortisone Cream	Topically	___MG ___ML	Q_____HRS	Insect bites, rash	
Cough Drops	PO	___MG ___ML	Q_____HRS	Cough, sore throat	
Antibiotic Cream	Topically	___MG ___ML	Q_____HRS	Cuts, scrapes	

**Non Prescription and Prescription Medications** (Please complete with patient's current regimen for both scheduled and prn medications. Use 2<sup>nd</sup> 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

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 # \_\_\_\_\_