Camper Name:_________________________
DOB:_________________________

TAPAWINGO ADVENTURE/CIT PHYSICAL EXAMINATION FORM 2023

Speculator, NY 12164

This form is to be completed and signed by a Licensed Medical Provider. A physical is required within **one year** of the camper session.

Camper Name:____ **Date of Physical**:_____________________________

DOB:_________________________ **B/P**:_____________ **Weight**:_____________ **Height**:__________

Additional Information for Health Care Staff: ____

____

IMMUNIZATION HISTORY – attach a copy of immunizations. A legal waiver must be signed by parents/guardians for conscientious exemption (NY State Immunization Exemption form can be filled out on the camper's profile online).

Medical History:

- ❒ No Health Concerns
- ❒ Anxiety
- ❒ Asthma
- ❒ ADHD, ADD
- ❒ Bone, Muscle Injury
- ❒ Depression
- ❒ Eating Disorder
- ❒ Seizure Disorder
- ❒ Sleep Problems
- ❒ Headaches/Migraines
- ❒ Head Injury/Concussion
- ❒ Diabetes (MD signature is required on a Diabetic Care Plan)
- ❒ Other:

Current Treatment/Limitations while at camp:

____

Dietary Restrictions (all restrictions must be listed here in order to be supported by camp kitchen):

____

Allergies – please describe reactions and management

❒ No Known Allergies

ALLERGEN	TREATMENT	ANAPHYLAXIS?
❒ Food:		
❒ Medication(s):		
❒ Insect Stings:		
❒ Other:		

In my opinion, this camper is fit for a very active wilderness camp. This includes but is not limited to: hiking in the wilderness for five consecutive days, rafting, rock climbing, caving, water sport activities, and navigating outdoor terrain on an island.

❒ Yes ❒ No

Camper Name:__________________________
DOB:__________________________

MEDICATION ADMINISTRATION AUTHORIZATION

New York State Law requires a physician's signature for any medication to be dispensed by the Camp Health Director. **No medications** will be given unless signed off by your physician.

New York State requires all prescription AND over-the-counter medications that are taken regularly by a camper to be listed on this form. This includes creams, supplements, vitamins, and essential oils.

DIAGNOSIS	MEDICATION	DOSAGE	FREQUENCY

OVER-THE-COUNTER MEDICATIONS The following non-prescription medications are stocked in the Camp Health Center and are given by the Health Director, on an as needed basis. Please **DO NOT** send any of the following to camp. **MEDICAL PERSONNEL ONLY**: All of the following may be given unless otherwise noted. Please **verify with parents/guardians** if selecting "no" for any OTC medication.

MEDICATION	NO
Acetaminophen (Tylenol)	
Ibuprofen (Advil, Motrin)	
Cough Drops	
Diphenhydramine (Benadryl)	
Phenylepherine Decongestant (Sudafed PE)	
DayQuil	
NyQuil	
Guaifenisen (Tussin)	
Chloraseptic Throat Spray	
Vitamin C	
Dramamine	
Immodium AD	
Tums	
Pepto-Bismol	
Laxatives (Milk of Magnesia, Senna or Bisacodyl)	
Muscle Rub (Bengay)	
Hydrocortisone Cream	
Visine	
Orajel	
Albuterol Inhalation Solution 0.083% via SVN	
Other:	

I have examined the patient herein described and have reviewed her health history.

Licensed Medical Provider Signature:____**Date:**___________

Physician Name (print):____**Phone Number:**________________
Address:____