# PHYSICAL EXAMINATION FORM 2022

Speculator, NY 12164

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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 for conscientious exemption (NY State Immunization Exemption form can be filled out on the camper's profile online)

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## 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:_____

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, which includes, but is not limited to: hiking, water sport activities and navigating outdoor terrain on an island**.

❒ Yes ❒ No

## 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) | |
| Dextromethorphan & Guafenesin (Robitussin DM) | |
| Cough Drops | |
| Diphenhydramine (Benadryl) | |
| Phenylepherine Decongestant (Sudafed PE) | |
| Day-Time Cold Capsules (DayQuil) | |
| Night-Time Capsules (NyQuil) | |
| Dimaphen DM (Dimetapp Cough and Cold) | |
| Chloraseptic Throat Spray | |
| Vitamin C | |
| Dramamine | |
| Immodium AD | |
| Tums | |
| Pepto-Bismol | |
| Laxatives (Milk of Magnesia, Senna or Bisacodyl) | |
| Triple Antibiotic Ointment | |
| Calamine Lotion | |
| Burn jel | |
| Aloe | |
| Muscle Rub (Bengay) | |
| Hydrocortisone Cream | |
| Visine | |
| Orajel | |
| Auro-Dri (Swimmer's Ear) | |
| Albuterol Inhalation Solution 0.083% via SVN | |
| Zyrtec | |
| Claritin | |
| Allegra | |
| Other: | |

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

**Licensed Medical Provider Signature:**_____**Date:**_____

**Physician Name (print):**_____**Phone Number:**_____

**Address:**_____