

CAMPER NAME: _____

HEALTH HISTORY

List any operations or serious injuries (with dates): _____

List any additional health history concerns/comments: _____

List all allergies to **food, medications** and **environmental factors**: _____

Current or Recurring Medical Conditions:
e.g. Heart defect/disease, convulsions, diabetes, bleeding/clotting, asthma, hypertension, psychiatric treatment, ADD/ADHD, bedwetting.

Diseases:
_____ Mumps, _____ Chicken Pox, _____ Measles, _____ German Measles,
_____ Mono, _____ Whooping Cough, _____ Other: _____

EMERGENCY CONTACT: An emergency contact is an adult other than a parent/guardian.
Name: _____ Relationship _____
Home Phone _____ Business Phone _____
Cell _____

SECTION 2-To be completed by Licensed Physician

HEALTH CARE RECOMMENDATIONS:
I have examined _____ **on** _____ **(Date)p.**
Height: _____ Weight: _____ Blood Pressure: _____
In my opinion, the above individual **is** _____ **is not** _____ able to participate actively in camp programs.
If not, describe limitations: _____
The applicant is under the care of a physician for the following conditions: _____

CAMPER NAME: _____

IMMUNIZATION RECORD

Vaccine	Month/Year	Month/Year	Month/Year	Month/Year
DTP				
TD (Tetanus/diphtheria)				
Tetanus				
Oral Polio				
MMR				
or Measles				
or Mumps				
or Rubella				
Haemophilus Influenza B				
Hepatitis B				
Varicella (Chicken Pox)				
Other				
Other				
TB Mantoux Test	Date of Last Test:		Result (+ or -)	

Prescription Medications

Please complete with patient's current regimen for both scheduled and PRN medications.

Medication	Dosage	Quantity per Dose	Schedule	Comments:

FOR LICENSED PHYSICIAN

Signature: _____ Date _____

License# _____

Phone# _____

Fax# _____

Date of Physical Exam _____ By: _____

Sign if completed by nurse or physician's assistant.

CAMPER'S NAME _____

AGE _____

Standard Over the Counter Medications

The following medications are available at the Health Center and will be administered at the discretion of the Health Director, with parent/guardian and physician's approval. Please select which medications below can be given.

Key: PRN (if needed) PO (taken by mouth) Topical (applied to skin) Q (every)

Drug Name	Route	Dosage	Schedule and Indications	Health Provider Order	Comments
Ibuprofen (e.g. Advil, Motrin)	PO (Chew tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hours PRN Pain, fever, cold symptoms, toothache, muscle aches	YES NO	
Acetaminophen (e.g. Tylenol)	PO (Chew tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hours PRN- Pain, fever, cold symptoms, toothache, muscle aches	YES NO	
Pseudoephedrine & Ibuprofen (e.g. Advil Cold and Sinus)	PO (Pills)	Per label instruction by age/weight	Q 4-6 hrs PRN Pain, fever, nasal congestion	YES NO	
Antacid (Mylanta or Tums)	PO (Pills or liquid)	Per label instruction by age/weight	Q 2-4 hrs PRN- Gas, heartburn, indigestion, stomach upset	YES NO	
Robitussin	PO (Liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN Coughs	YES NO	
Cough Drops and Lozenges	PO (Lozenges)	Per label instruction by age/weight	PRN Coughs, Sore Throats	YES NO	
Diphenhydramine (e.g. Benadryl)	PO/Topical (Pills, Liquid, Spray)	Per label instruction by age/weight	PRN- Insect bites, allergies, respiratory allergies	YES NO	
Pseudoephedrin (e.g. Sudafed)	PO (Chew tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs- Nasal/sinus congestion, hay fever, allergies	YES NO	
Ivy Block and Tecnu	Topical (Cream)	Per label instruction	Q 4 hrs PRN Contact with poison ivy	YES NO	
Calagel and Hydrocortisone	Topical (Cream)	Per label instruction	Q 6-8 hrs PRN Rash, skin irritation	YES NO	
Calamine	Topical (Cream or Gel)	Per label instruction	PRN- Insect bites, skin irritation, rash	YES NO	
Medicaine	Topical (Liquid)	Per label instruction	PRN Insect Stings	YES NO	
Antiseptics (Alcohol, Peroxide, Bacitracin)	Topical (Cream or Liquid)	Per label instruction	PRN- Stings/bites, cuts, scrapes, splinters, blisters	YES NO	
Betadine (contains Iodine)	Topical (Liquid)	Per label instruction	PRN- Cuts, scrapes, splinters, blisters	YES NO	
Antifungal Cream/Spray	Topical (Cream or Spray)	Per label instruction	PRN- Athletes Foot	YES NO	
Cooling Gel and Aloe	Topical (Cream or Gel)	Per label instruction	PRN- Burns, sunburn, wind burn	YES NO	
Orasol, Ambesol and Abreva	Topical (Liquid or Cream)	Per label instruction	Q 6 hrs PRN- cold sores, toothache	YES NO	
Visine	Optical (Liquid)	Per label instruction	PRN- eye strain, eye irritation	YES NO	
Acetic Acid Solution	Otic (Liquid)	Per label instruction	PRN- Swimmers Ear	YES NO	
Sunscreen		Per label instruction	PRN	YES NO	
Insect Repellent		Per label instruction	PRN	YES NO	
Zyrtec	PO (pills)	Per label instruction	4-6 hrs, PRN, mild seasonal allergies	YES NO	
Claritin	PO (pils)	Per label instruction	4-6 hrs., PRN, mild seasonal allergies	YES NO	
Pink Bismuth	PO (liquid)	Per label instruction	2-4 hrs., upset stomach, diarrhea	YES NO	

Parent/Guardian Signature: _____ Date _____