DUNCAN PARK

Proof of Physical Form: **Before attending camp at Duncan Park (DP), a physical is required.**

If a camper has had a physical within 24 months of the first day of camp, the physician may complete and sign this form based on that exam; **the signature must be within 6 months of the first day of camp.**

After this form is signed, it is the responsibility of camper's parent/guardian to send it to John Knox Ranch. JKROffice@missionpby.org

Camper's Full Name: _____ **Date of Birth:** _____

DP Session Camper is Attending: _____ **Session Start Date:** _____

HEALTH CARE RECOMMENDATIONS – To Be Completed by an MD or DO.

☐ Duncan Park requires a health exam within 6 months of camp attendance. A brand new exam is not necessarily required for camp attendance.

I examined this individual on _____. In my opinion, they ☐ *are* ☐ *are not* able to participate in an active camp program.

BP: _____ Weight: _____ Height: _____

The applicant is under the care of a physician for the following conditions: _____

_____

_____

Treatment to be continued at Duncan Park: _____

_____

_____

Medications to be administered at camp (name, dosage, frequency): _____

_____

_____

Limitations or restrictions while at camp: _____

_____

_____

Other information for the Camp Health Staff:

Signature of Licensed Medical Personnel: _____ (date) _____

Printed Name: _____ Title: _____

Practice Name: _____ Phone: _____

Address: _____

DUNCAN PARK

MEDICAL RELEASE FORM to be completed by a Physician

Camper's Name:_____

Date of Birth: _____ Age _____

Primary Physician's Name _____ Primary Physician's Phone Number _____

PROOF OF PHYSICAL: _____

I, _____ (Name of Physician), consider_____ (Name of Camper) to be in good health, free of any communicable diseases and able to participate in summer camp related activities including but not limited to high altitude hiking, rock climbing, rafting, camping, field games, etc.

I also hereby swear that _____(Name of Camper) has had a physical in the last 24 months.

Physician Signature _____Date _____

MEDICATION RELEASE – OVER THE COUNTER (OTC): _____

_____ (Name of Camper) has medical permission while at Duncan Park to receive:

	Reason:	Dosage:	Frequency:
_____Tylenol			
_____Ibuprofen			
_____Benadryl			

*These are the only medications supplied by Duncan Park. List any additional OTC medications or prescription below.

Physician Signature _____ Date _____

MEDICATION RELEASE – PRESCRIPTION OR ADDITIONAL OTC: _____

_____ (Name of Camper) has medical permission to receive the prescription and/or OTC medications listed below while at Duncan Park.

Medication (Rx or OTC?)	Reason:	Dosage:	Frequency:

Physician Signature _____ Date _____

Any prescription drugs need to be in original bottle from the pharmacy with instructions on dose and frequency given that matches the chart above. We cannot administer prescriptions or OTC medications without physician's signature, or that are expired. We suggest a few extra days of medications for unforeseen circumstances. The State of Colorado is very careful when it comes to medications. This is in order to protect children from reactions to unknown allergies and overdose. We thank you for your attention to detail in this matter!

COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH STUDENT ATTENDING COLORADO SCHOOLS

Name _____ Date of Birth _____

Parent/Guardian _____

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT—CERTIFICATE OF IMMUNIZATION

Vaccine		Enter the month, day and year each immunization was given					
Hep B	Hepatitis B						
DTaP	Diphtheria, Tetanus, Pertussis (pediatric)						
DT	Diphtheria, Tetanus (pediatric)						
Tdap	Tetanus, Diphtheria, Pertussis						
Td	Tetanus, Diphtheria						
Hib	*Haemophilus influenzae* type b						
IPV/OPV	Polio						
PCV	Pneumococcal Conjugate						
MMR	Measles, Mumps, Rubella						
Measles	Measles						
Mumps	Mumps						
Rubella	Rubella						
Varicella	Chickenpox			Healthcare Provider Documentation Date		Lab Verification Date	
Vaccines recorded below this line are recommended. Recording of dates is encouraged.							
HPV	Human Papillomavirus						
Rota	Rotavirus						
MCV4/MPSV4	Meningococcal						
Hep A	Hepatitis A						
TIV/LAIV	Influenza						
Other							

THIS SECTION CAN BE COMPLETED BY CHILD CARE/SCHOOL/HEALTH CARE PROVIDER

☐ **A) Child Care Up to Date**
Up to date through 6 months of age for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **B) Child Care Up to Date**
Up to date through 18 months of age for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **C) Child Care/Pre-school/Pre-K***
Up to date for Child Care/Pre-School/Pre-K for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **D) Complete for K–5th Grade**
Up to date for K–5th Grade for Colorado School Immunization Requirements — Update Signature _____ Date _____

* If age 4 years and fulfills Requirements for Pre-School & Kindergarten, check BOTH Boxes C and D

HAS MET ALL IMMUNIZATION REQUIREMENTS FOR COLORADO SCHOOLS (6TH GRADE OR HIGHER)

Signed _____ (Physician, nurse, or school health authority) Title _____ Date _____

Name_____ Date of Birth _____

Parent/Guardian _____

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW
(DECLARACIÓN RESPECTO A LAS EXENCIONES DE LA LEY DE VACUNACIÓN)

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM SCHOOL AND TO QUARANTINE.

SI SE PRESENTA UN BROTE DE LA ENFERMEDAD, ES POSIBLE QUE A LAS PERSONAS EXENTAS SE LES PONGA EN CUARENTENA O SE LES EXCLUYA DE LA ESCUELA.

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

EXENCIÓN POR RAZONES MÉDICAS: El estado de salud de la persona arriba citada es tal que la vacunación significa un riesgo para su salud o incluso su vida; o bien, las vacunas están contraindicadas debido a otros problemas de salud.

***Medical exemption** to the following vaccine(s):*

***La exención por razones médicas** aplica a la(s) siguiente(s) vacuna(s):*

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

Signed (Firma) _____ Date (Fecha) _____

Physician (Médico)

RELIGIOUS EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

EXENCIÓN POR MOTIVOS RELIGIOSOS: El padre o tutor de la persona arriba citada, o la persona misma, pertenece a una religión que se opone a la inmunización.

***Religious exemption** to the following vaccine(s):*

***Exención por motivos religiosos** de la(s) siguiente(s) vacuna(s):*

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

Signed (Firma) _____ Date (Fecha) _____

Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)

PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

EXENCIÓN POR CREENCIAS PERSONALES: Las creencias personales del padre o tutor de la persona arriba citada, o la persona misma, se oponen a la inmunización.

***Personal exemption** to the following vaccine(s):*

***Exención por creencias personales** de la(s) siguiente(s) vacuna(s):*

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

Signed (Firma) _____ Date (Fecha) _____

Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)