

2025 Camp Reid Physician Examination Form

Camp Fire, 7070 E. Carson St., Long Beach, CA 90808

Phone: (562) 421-2725

Fax: (562) 421-4056

www.campfirelb.org

Office Use Only

Socks: _____ Shoes: _____ Dr. Sig: _____

My child is NOT taking cell phone, electronic gear, candy, gum, or other restricted items up to camp.

Parent Signature

THIS SIDE TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN

Camper Name _____ Birth date: _____ / _____ / _____ ☐ M ☐ F

Parent/Guardian Name _____ Cell Phone: (_____) _____

Home Address: _____ Work Phone: (_____) _____

Alternate Phone: (_____) _____

Has your child slept away from home before? _____ Any concerns you wish the staff to know about? ☐ Yes ☐ No

If yes, please explain: _____

List any medications currently in use, including insulin: _____

List any known physical, mental, social difficulties or other specific information which may affect participation and/or for which special consideration should be given: _____

(Attach notes when additional space is needed)

Date of last physical exam (well or sick call): _____

All medications must be turned in on the day of departure at the pre-departure health check. A health care professional will be on duty to check in medications. All medications must be in the original container and include dosage and directions. Asthma medication and bee sting kits will stay with the camper at all times.

MEDICAL EMERGENCY INFORMATION DURING CAMP

Occasionally, parents decide to schedule a vacation while their kids are well taken care of at camp. Very rarely, a child has needed medical attention at an urgent care or emergency room while their parents are away. Based on the diagnosis by health practitioners, the child may need home-based care for the remainder of the week. If this should occur, the parents or designated emergency contacts will need to be able to pick up the child within three hours of notification.

Please let us know if you will be in or out of town while your child is at camp:

- ☐ I/we will be in town while my/our child is at camp.
☐ I/we will be out of town; the dates I/we will be away from home are: _____

Name of the location I/we will be staying: _____

Address of location: _____ Phone: (_____) _____

The emergency contacts listed on camp registration form are aware they are listed and could be called in the event of an emergency.

- ☐ Yes ☐ No

The emergency contacts have a copy of my/our child's most recent medical insurance card.

- ☐ Yes ☐ No

The emergency contacts are aware they could be required to give permission for emergency medical care.

- ☐ Yes ☐ No

The emergency contacts are aware they could be required to pick up my/our child from camp or emergency care facility within three hours of contact.

- ☐ Yes ☐ No

Parent/Guardian Signature _____ Date _____

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THIS SIDE MUST BE COMPLETED AND SIGNED BY CAMPER'S PHYSICIAN

EXAM MUST BE WITHIN THE LAST 12 MONTHS TO BE CONSIDERED CURRENT

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Meds:_____Temp:_____

Head:_____Feet:_____

Unit:_____

HEALTH EXAMINATION BY LICENSED PHYSICIAN

Camper Name _____Date examined _____

The applicant is under the care of a physician for the following condition(s) _____

In my opinion, the above condition does _____/does not _____preclude his/her participation in an active camp program.

Current treatment (include current medication) _____

Does the camper have epilepsy? _____Does the camper have diabetes? _____

Does the camper have asthma? _____Does the camper have athlete's foot? _____

Does the camper have allergies requiring special attention, i.e., peanuts, bee stings...? _____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP

Any treatment to be continued at camp: _____

Any medication to be administered while at camp (specify dosage): _____

Any special dietary restrictions: _____

Additional health information: _____

Physician's Name: _____Phone (_____) _____

Address: _____
Street AddressCityStateZip Code

Licensed Physician's Signature _____Date _____