Camp Sacandaga 117 Page Street, PO Box 632, Lake Pleasant, NY 12108 (p)518 548 4742 (f)518 548 4743 office@campsacandaga.com

MEDICAL EXAMINATION by LICENSED MEDICAL PERSONNEL

Camper Session: ____________________

Camper Name : ____________________

Gender:__________DOB: __________

Please have your child's primary healthcare provider complete this form. Once complete, scan and upload the document to your account or email /fax it to camp.

Keep the original copy for your own records

Physical exam performed today? ◻ Yes ◻ No Date: _______

If "No", date of last physical exam? ____________________

Weight:__________
Height:__________
Blood Pressure:__________

Conditions : List conditions for which the camper is receiving treatment, including Behavior Issues and Plans. ☐ **None**

Restrictions : List Activity Restrictions. ☐ **No Restricitions**

Diet /Nutrition : List Dietary Restrictions ☐ **Eats regular diet**

Allergies : List all allergies and reactions ☐ **No known allergies**

Physician Authorization: I have reviewed the patient health history form and have discussed the camp program with the patient's parents/guardians. It is my opinion that the patient is physically and emotionally fit to participate in an active camp program (except as noted above).

Address: ____________________**City:** __________ **State:** ________ **Zip Code:** ________

Phone: ____________________

____________________ ____________________ ________

Name of Licensed Provider **Signature** **Date**

PARENTS PLEASE FILL OUT!!!

INSECT REPELLENT AND SUN SCREEN

☐ **My child may carry and use insect repellent.** ☐ **My child may NOT carry and use insect repellent.**

☐ **My child may carry and use sunscreen.** ☐ **My child may NOT carry and use sunscreen.**

Notes for Insect Repellent or Sunscreen:____________________**Initials** ☐

MEDICATION AUTHORIZATION FORM (REQUIRED: SUBMIT completed form to Camp Nurse at check-in or email to camp office)	Camper Session: ______________________ Camper Name : ______________________ Gender:__________DOB: __________

Please look over and give this form to your physician to fill out.

1. **A "medication" is ANY substance taken to maintain and/or improve health. This includes any medication, prescription drugs, vitamins and natural remedies.**
2. NYS law requires a physician's signature for any medication to be dispensed by our Camp Nurse. ***NO medications of any sort will be dispensed to your child without your doctor's signature of approval on this form.***
3. Please review in entirety this form and complete as necessary to allow or disallow medication dispensation to your child.

The following medications are provided by Camp and dispensed by the camp nurse with assessment and if deemed necessary, given as prescribed by the manufacturer's recommended dosage.

Medical personnel only: Please review and Cross out any medication that CAN NOT be given.

Acetaminophen (Tylenol)
Ibuprofen (Advil; Motrin)
HYDROCORTISONE 1%
Phenylephrine decongestant (Sudafed PE)
Antihistamine/allergy medicine
Pseudoephedrine decongestant (Sudafed)
Diphenhydramine antihistamine/allergy medicine (Benadryl)
Calamine lotion
Lice shampoo or cream (Nix or Elimite)
Bismuth subsalicylate for diarrhea (Kaopectate; Pepto-Bismol)
Laxatives for constipation (Ex-Lax)
Antibiotic cream
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Sore throat spray
Guaifenesin cough syrup (Robitussin)
Sunscreen
Insect Repellent
Aloe
Burn Spray

☐ ALL MEDICATIONS / ITEMS LISTED MAY BE GIVEN

PRESCRIPTION & OTHER MEDICATIONS AS DEFINED ABOVE

All prescription and other medications must be brought to camp in the original container with the label attached. The AUTHORIZATION SCHEDULE herein must be completed for each medication by the child's physician. Physician must give contact information and authorize dispensation with his/her signature.

Medical personnel only: Check the appropriate option below.

☐ **THIS CAMPER WILL NOT TAKE ANY DAILY MEDICATIONS WHILE ATTENDING CAMP.**

☐ **This CAMPER WILL take the following daily prescription medications or other non-prescription medications not provided by camp as listed below.**

Diagnosis	Medication	Dosage	Frequency	Instruction
			☐ BREAKFAST ☐ LUNCH ☐ DINNER ☐ BEDTIME ☐ AS NEEDED (EXPLAIN)	
			☐ BREAKFAST ☐ LUNCH ☐ DINNER ☐ BEDTIME ☐ AS NEEDED (EXPLAIN)	
			☐ BREAKFAST ☐ LUNCH ☐ DINNER ☐ BEDTIME ☐ AS NEEDED (EXPLAIN)	

Authorizing Physician's Name ______________________ **Signature:**______________________

Parent/Guardian Name ______________________ **Signature:**______________________

Day Phone:______________________

REFUSAL: NO OTC OR PRESCRIPTION DRUGS ADMINISTERED. PHYSICIAN SIGNATURE NOT REQUIRED. INITIAL TO REFUSE