TO BE COMPLETED BY EXAMINING PHYSICIAN

Camper's name _____

Home address_____ City_____ State _____ Zip_____

Weight _____ Height _____

Immunization History:

Please record month and year of basic immunizations and most recent booster

Immunization	Date basic series completed	Most recent booster
DPT or DT		
Tetanus		
Oral polio		
MMR		
PPD/Mantoux		
Hepatitis A		
Hepatitis B		
Varicella		

Allergies:	Yes	No	Comments
Penicillin			
Sulfa			
Other medication			
Food allergies *List foods your child is allergic to.*			
Bee/insect bites			

Indicate if your child has ever had an anaphylactic reaction.
If yes, are you sending your child with an EpiPen? ☐ Yes ☐ No

Medical history Indicate date of illness

Chicken pox: _____/_____/_____
Measles: _____/_____/_____
German measles: _____/_____/_____
Mumps: _____/_____/_____
Hepatitis: _____/_____/_____
Pneumonia:_____/_____/_____
Other:_____

If being treated for the following,

Please make sure the camp medical staff is notified before camp begins, and indicate the condition below:

☐ Diabetes ☐ Seizures ☐ Seasonal allergy ☐ Rheumatic fever

☐ Ear infections ☐ Strep throat ☐ Asthma- If your child is being treated for asthma, please send along the tubing for the nebulizer as well as all inhalers being used.

☐ Positive PPD Date _____/_____/_____

☐ CXRay Date _____/_____/_____

Individualized Orders

Standard over-the-counter/PRN medications, available in the infirmary/first aid kit, to be administered at the discretion of Medical Director.

DRUG*	ROUTE	DOSAGE	SCHEDULE	CONTRA-INDICATED Check only if med is NOT to be given	COMMENTS
Tylenol	PO	Per label instructions by age/weight	q 6 hr prn for discomfort or elevated temp		
Ibuprofen	PO	Per label instructions by age/weight	q 4 hr prn for discomfort or elevated temp		
Robitussin	PO	Per label instructions by age/weight	q 4 hr prn for cough		
Pepto-Bismol	PO	Per label instructions by age/weight	q 30 min to 1 hr prn for diarrhea (not >8 doses/24hr)		
Mylanta	PO	Per label instructions by age/weight	TID-QID prn for gastric upset		
Dramamine	PO	Per label instructions by age/weight	½ hr before embarkation, then q 6-8 hr prn for motion sickness		
Benadryl	PO	Per label instructions by age/weight	q 6 hr prn for allergic reaction		
Sudafed	PO	Per label instructions by age/weight	q 6-8 hr for nasal congestion/ drainage		
Tums	PO	Per label instructions by age/weight	Gastric upset/heartburn		
NaphconA	Eye gtts	Per label instructions by age/weight	1-2gtts affected eye for itching/burning		
Milk of Magnesia	PO	Per label instructions by age/weight	BID-TID prn for gastric upset/constipation		
Ear drops	TOP	Per label instructions by age/weight	As indicated		
Cortisone ointment	TOP	Per label instructions by age/weight	As indicated		
Antifungal ointment spray	TOP	Per label instructions by age/weight	As indicated		

* or generic equivalent

List any medications child is currently taking:

List dates & description of operations, serious injuries, or fractures: _____

_____

Describe any mental or psychological conditions requiring medication, treatment, or special restrictions: _____

_____

Chronic or recurrent illness, and suggested treatment: _____

_____

SPECIAL RESTRICTIONS: Diet _____ Swimming_____

Strenuous activity_____ Other _____

To the best of my knowledge the information stated above is true and accurate, and it is my opinion that the camper named above is physically able to engage in all camp activities, except as noted above.

_____

Physician's signature Date

_____

Physician's name Address Office/emergency phone #

STAMP