

Camp Rince Ceol Physical Examination Form 2008

Session _____

Camper Name _____ DOB _____ Age _____

Gender _____ Examined By _____ Date _____



Height:	
Weight:	
BP:	

Allergies:	
1. Drugs:	
2. Environmental:	
3. Food:	

Dietary Requirements:

ALL CATEGORIES (FRONT & BACK) MUST BE ADDRESSED AND COMPLETED

(As mandated by the NY & CA Health Depts.)

MEDICAL HISTORY
(check all that apply)

- ADD/ADHD
- ANAPHYLAXIS
- ASTHMA-EIA
- CARDIAC DISEASE
- DIABETES
- EATING DISORDER
- EMOTIONAL DISORDER/ANXIETY
- ENURESIS
- FAINTING
- FRACTURES
- HAYFEVER
- HEADACHES
- MIGRAINES
- SCOLIOSIS
- SEIZURE DISORDER
- SHIN SPLINTS
- SPRAINS
- THYROID DISORDER
- VISUAL DISORDER
- OTHER

IMMUNIZATION RECORD
If Immunization not given for medical or religious reasons attach MD/Parent – signed statement

DPT/DTaP	1)	2)	3)	4)	5)
Td	1)	Recommended every 10years			
POLIO	1)	2)	3)	4)	5)
MMR	1)	2)			
MUMPS	1)				
Hib	1)	2)	3)	B	
HEP B	1)	2)	3)		
VARICELLA	1)	2)			
MENINGOCOCCAL	1)				
PNEUMOCOCCAL	1)	2)	3)		
INFLUENZA (yearly)	1)				
OTHER					

SCREENINGS

Type	Date	Result	Type	Date	Result	Type	Date	Result
TB			HGB			HbA1C		
Tine				5 34 5v				
Mantoux								

Pertaining to above MEDICAL HISTORY, please clarify and identify special needs while attending camp (use separate sheet if necessary)

Does Camper have any significant or recent fracture, sprain or orthopedic condition?

Does camper require the use of any orthopedic device, brace or bandage? If yes, please clarify (be sure to bring devices with you to camp)

Is camper able to participate in a very strenuous dance program and other active sports and camp activities? Yes No

If no explain: _____

ALL CATEGORIES PERTAINING TO MEDICATIONS MUST BE COMPLETED BY PHYSICIAN/PA

Prescription Medications: if none check here

Complete the following according to camper's current regimen. Use separate sheet if necessary

DRUG NAME	DOSE/ROUTE	INTERVAL	REASON

OTC – Stock Medications:

Camp Rince Ceol stocks all medications listed below. *Unless otherwise indicated by the camper's physician or PA* in the comment column below, PRN medications and Topical Medications may be administered at the discretion of the Camp Nurse according to complaint, age and weight.

<i>PRN Medications</i>	<i>Comment</i>
ACETAMINOPHEN:	
Tabs	
Chewable tabs	
Elixir	
IBUPROFEN:	
Tabs	
Chewable tabs	
Suspension	
GUAIFENESIN (expectorant):	
Solution	
SIMETHICONE:	
Chewable tabs	
CALCIUM CARBONATE (regular strength):	
Chewable tabs	
DIMETAPP ELIXIR	
DIPHENHYDRAMINE HYDROCHLORIDE:	
Tabs	
Elixir/syrup	

<i>Topical Medications</i>	<i>Comment</i>
ANTI-ITCH CREAM	
BACITRACIN	
BETADINE	
BEN-GAY	
CALAMINE LOTION	
EYE WASH	
HYDROGEN PEROXIDE	
INSECT REPELLENT	
RUBBING ALCOHOL	
SUNSCREEN	
TRIPLE ANTIBIOTIC CREAM	

MEDICAL STATEMENT & RELEASE

The above named Camper has been examined and on the basis of my findings, as indicated on the Health Form and my knowledge of the applicant, I find that he/she *is able to participate in an active camp program*. I have reviewed and completed the **medication portion** of this form (Prescription, PRN's and Topical)

Physician's Signature _____ **Date** _____

Telephone # _____

Stamp
