COLORADO LIONS CAMP PHYSICAL EXAMINATION

Colorado Lions Camp requires this form to be completed and signed by a Licensed Physician NOT by a parent or caregiver. Form must be dated within 12 months of the last day of the camper's session. Form must be turned in to Colorado Lions Camp 2 weeks prior to the first day of camper's session.

Name: _____ Date of Birth:_____/_____/_____ Male ____ Female____
Diagnosis:_____
Other medical conditions: _____
Allergies (Drug/Food/Environmental): _____

EXAMINATION COMPLETED BY PHYSICIAN:

Height: Weight:	Mouth/Throat/Nose:
Pulse: BP: Temp: O2:	Neck/Thyroid & Lymph Sys:
Hearing Loss:(circle) NONE PARTIAL COMPLETE Uses: Hearing Aids Cochlear Implant	Nervous System/Reflexes/Gait/Sensations:
Vision Loss:(circle) NONE PARTIAL COMPLETE Uses: Glasses Contacts	Uses:(circle) CPAP Oxygen (only at night)
Cardiac:	GI Distress:(circle) Upper Lower (please specify)
Lungs:	Headaches:
Abdomen:	Bedwetting:
Musculoskeletal:	Incontinence:(circle) Urinary Fecal (please specify)
Back/Spine:	Respiratory/Asthma/Emphysema (please specify)
Skin:	Sleep Apnea/COPD:
Diabetic: Insulin: YES NO Frequency of glucose monitoring:	Seizures: Type: Frequency: Date of Last Seizure: Please attach seizure protocol if it applicable
Mobility: List Mobility aids used:	

PREVIOUS ILLNESS (give age when these occurred): Chicken Pox _____ Measles _____ Mumps _____ MRSA _____ Shingles/Herpes _____ Strep Throat _____ Hepatitis _____ Frequent UTI _____ Frequent URI _____ Chronic Cough _____ High BP _____ Other _____

IMMUNIZATION HISTORY Please give dates (month/year) of immunizations and most recent booster dates: DTaP _____ MMR _____ Polio _____ Smallpox _____ Influenza _____ TB Test _____ Hepatitis B series _____ Tetanus _____ Type _____ Covid-19_____

***Campers ages 8-21 must attach copy of current immunization record. If records are unavailable, please send statement to that effect. Statement "up-to-date" not acceptable.**

Additional Questions

1. Is applicant considered healthy enough to attend camp at 8000 ft elevation YES NO
2. Is applicant free from communicable diseases? YES NO If no, please specify:
   _____
3. How would you assess the applicant's current health? GOOD FAIR POOR
4. Has the applicant been hospitalized or treated in the emergency room in the last year? YES NO If yes, specify _____
5. Is applicant a carrier of Hepatitis B or C has he/she been exposed to Hepatitis B or C? YES NO
6. Does this camper have a diagnosis, such as Atlantoaxial Instability or any other, that will prevent him/her from participating in any activities such as: swimming, supervised ropes course, hiking, and archery? YES NO If yes, specify: _____

OTC Medications

The Camp Medical Professional may administer age/weight appropriate dose of the medications listed below from approved CLC Standing Orders. Indicate if these medications are appropriate for this camper below.

Triple Antibiotic Ointment (Neosporin)
Ibuprofen (Motrin/Advil)
Acetaminophen (Tylenol)
Milk of Magnesia
Anti-diarrheal (Loperamide/Imodium)
Glycerin Suppository or Enema
Pepto Bismol
Antacid (Tums/Mylanta)
Famotidine (Pepcid/Zantac)
Dulcolax or Sennakot
Preparation H
Campho Phenique/Blistex
Cough drops/Chloraseptic spray
Robitussin/Robitussin DM
Sudafed

Antifungal Cream
Benzocaine (topical for stings, scrapes, sunburn)
Bug Repellent Spray
Sunscreen
Aloe Vera
Visine Eye Drops
Hydrocortisone Cream
Calamine Lotion
Orajel
Vagisil Cream
Melatonin
Diphenhydramine (Benadryl) PO or topical
Albuterol (rescue inhaler or nebulizer)
EpiPen (To be used if Camp Medical Professional suspects anaphylaxis only)

Please choose <u>one</u> option:

- ☐ **Yes, ALL of the above listed medications may be given**
- ☐ **No, the following OTC medications should NOT be given to this camper**

_____

Physician's signature: (required)_____ **Date** _____

Physician's Name (Please Print) _____ Phone: _____

Address, City, State, Zip: _____

MEDICATION ORDER FORM AND ADMINISTRATION RECORD

Colorado State Law requires a written order from an authorized prescriber for the Camp Medical Professional to administer medication. This includes all over the counter meds, supplements, herbs, and topical medications.

☐ Check here to indicate that this camper **does not take ANY medication**. **Form must still be signed.**

Name of Camper:_____ **Columns to be completed by Camp Medical Professional**

Please clearly print the medication name, dose, route, reason for use and circle times to be given for EACH medication.		Sun	Mon	Tue	Wed	Thu	Fri
	Date						
	Times to be given (circle)						
Medication:	Breakfast (8 AM)						
	Lunch (12 PM)						
Dose:	Dinner (5:30 PM)						
	Bedtime (8:30 PM)						
Route:	PRN						
Reason for use:	Other _____						
Medication:	Breakfast						
	Lunch						
Dose:	Dinner						
	Bedtime						
Route:	PRN						
Reason for use:	Other _____						
Medication:	Breakfast						
	Lunch						
Dose:	Dinner						
	Bedtime						
Route:	PRN						
Reason for use:	Other _____						
Medication:	Breakfast						
	Lunch						
Dose:	Dinner						
	Bedtime						
Route:	PRN						
Reason for use:	Other _____						

Physician's Signature (required) _____ **Date** _____

Physician's Name (Please Print) _____

Signature of staff administering medication: _____ Initials: _____ Date:_____

MEDICATION ORDER FORM AND ADMINISTRATION RECORD (cont.)

Name of Camper:_____

Please clearly print the medication name, dose, route, reason for use and circle times to be given.		Sun	Mon	Tue	Wed	Thu	Fri
	Date						
Medication:	Breakfast (8 AM)						
	Lunch (12 PM)						
Dose:	Dinner (5:30 PM)						
	Bedtime (8:30 PM)						
Route:	PRN						
Reason for use:	Other _____						
Medication:	Breakfast						
	Lunch						
Dose:	Dinner						
	Bedtime						
Route:	PRN						
Reason for use:	Other _____						
Medication:	Breakfast						
	Lunch						
Dose:	Dinner						
	Bedtime						
Route:	PRN						
Reason for use:	Other _____						
Medication:	Breakfast						
	Lunch						
Dose:	Dinner						
	Bedtime						
Route:	PRN						
Reason for use:	Other _____						
Medication:	Breakfast						
	Lunch						
Dose:	Dinner						
	Bedtime						
Route:	PRN						
Reason for use:	Other _____						

Physician's Signature (required) _____ **Date** _____
Physician's Name (Please Print) _____

Signature of staff administering medication: _____ Initials: _____ Date:_____