

## Camp Physical Examination

*This form must be completed and signed by a Licensed Physician **NOT** by a parent or caregiver.*

We request this form or a copy of our physical dated no later than **12 months** from your camp date be received in our office at least **FOUR WEEKS** prior to the scheduled camp session.

Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_

Diagnosis: \_\_\_\_\_

Is any condition present, which may result in an emergency? Please describe: \_\_\_\_\_

Allergies (Drug/Food/Environmental): \_\_\_\_\_

### EXAMINATION COMPLETED BY PHYSICIAN

|  |                 |   |
|--|-----------------|---|
| Height:  | Weight:         | Mouth/Throat/Nose:                              |
| Pulse:   | BP:             | Temp:   |
| <b>Hearing Loss:</b> NONE PARTIAL COMPLETE<br>Hearing Aids Worn? Cochlear Implant? |                 | Nervous System/Reflexes/Gait/Sensations:        |
| <b>Vision Loss:</b> NONE PARTIAL COMPLETE<br>Glasses Worn? Contacts Worn?          |                 | Bringing to camp: CPAP or Oxygen (CIRCLE) NIGHT |
| Cardiac:   |                 | GI Distress - upper - lower (please specify)    |
| Lungs:   |                 | Headaches:                                      |
| Abdomen:   |                 | Bedwetting:                                     |
| Musculoskeletal:   |                 | Incontinence – Urinary - Fecal (please specify) |
| Back/Spine:  |                 | Respiratory/Asthma/Emphysema (please specify)   |
| Skin:  |                 | Sleep Apnea/COPD:                               |
| Diabetic:  | Insulin: YES NO | Seizures: Type:                                 |
| Frequency of glucose monitoring:   |                 | Frequency: Last:                                |
| Mobility   |                 | Uses: WALKER CANE WHEELCHAIR                    |

**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:  
 (DPT) \_\_\_\_\_ MMR \_\_\_\_\_ Polio \_\_\_\_\_ Smallpox \_\_\_\_\_ Influenza \_\_\_\_\_  
 TB Test \_\_\_\_\_ Hepatitis b series \_\_\_\_\_ Tetanus \_\_\_\_\_ Type \_\_\_\_\_ **(REQUIRED)**  
 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.**

### QUESTIONNAIRE

- Is camper free from communicable diseases? YES/NO If no, please describe: \_\_\_\_\_
- How would you access the applicant’s current health? GOOD FAIR POOR
- Has the applicant been hospitalized or treated in the emergency room in the last year? YES NO
- If yes, please explain. \_\_\_\_\_
- Is the applicant a carrier of Hepatitis B or C has he/she been exposed to Hepatitis B or C? YES NO
- Are there medical reasons to limit or restrict this individual from participating in the following camp activities: swimming, horseback riding, supervised ropes course, hiking, and archery? \_\_\_\_\_ Any limitations? \_\_\_\_\_

Colorado State Law and Regulations require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician’s assistant) for the nurse or designated trained personnel to administer medication. Please provide complete information on all medications, including prescription and nonprescription medications, dietary supplements, and homeopathic remedies. **Nonprescription, dietary supplements and homeopathic remedies will NOT be given at camp unless prescribed by a physician.**

Camper’s Name: \_\_\_\_\_

Any changes in how the medication is given or in a dose that differ from those on the bottle must be verified by a physician in writing or the healthcare staff **WILL REFUSE** to administer it.

**PLEASE CHECK ONE OF THE FOLLOWING:**

- Camper takes no medication
- Camper takes daily medication as follows: **standard camp medication times are listed in the chart below. Please complete the chart with accurate and current medication information.** If camper cannot adhere to these times, please indicate alternate time and why medication must be given at that time. Please indicate number of tablets, capsules, amount of liquids, or puffs of inhalers, etc. in the box below the time medication is given.

**MEDICATION SHEET**

**PLEASE PRINT CLEARLY- MUST BE FILLED OUT BY PHYSICIAN'S OFFICE STAFF ONLY**  
**DO NOT WRITE "SEE ATTACHED"** IF CAMPER USES MEDICAL MARIJUANA IT NEEDS TO BE APPROVED BY  
**A PHYSICIAN TO BE ADMINISTERED AT CAMP**

**Any attachments (for clarification) must clearly state the medication, dosage, and reason for use and the time meds must be given. Use the Medication Sheet continuation form for additional medications.**

| Medication | Dosage & # of pills, puffs, liquid | Reason for Use | 8:00am<br>Breakfast | 12:00pm<br>Lunch | 3:30pm<br>Snack | 6:00pm<br>Dinner | 8:30pm<br>Bedtime | Other |
|------------|------------------------------------|----------------|---------------------|------------------|-----------------|------------------|-------------------|-------|
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|            |                                    |                |                     |                  |                 |                  |                   |       |

*Camp Nurse may administer age/weight appropriate dose of the medications listed below from approved CLC Standing Orders.*

|  |           |                             |           |                  |           |
|--|-----------|-----------------------------|-----------|------------------|-----------|
| Triple Antibiotic Ointment (Neosporin) | Yes or No | Ibuprofen (Motrin/Advil)    | Yes or No | Milk of Magnesia | Yes or No |
| Anti-diarrhea (Loperamide/Imodium)     | Yes or No | Acetaminophen (Tylenol)     | Yes or No | Pepto Bismol     | Yes or No |
| Glycerin Suppository or Enema          | Yes or No | Antacid (Tums/Mylanta)      | Yes or No | Bug Spray        | Yes or No |
| Diphenhydramine (Benadryl)             | Yes or No | Hydrocortisone Cream        | Yes or No | Sunscreen        | Yes or No |
| Dulcolax or Bisacodyl tabs             | Yes or No | EpiPen (Allergic Reactions) | Yes or No |                  |           |

Does the camper experience any side effects from the above medications? YES / NO

If yes, please explain. \_\_\_\_\_

**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 climbing, horseback riding or outdoor activities? Yes or No If Yes, please explain: \_\_\_\_\_**

**Physician's signature: (MANDATORY)** \_\_\_\_\_ **Date** \_\_\_\_\_  
Physician's Name (Please Print) \_\_\_\_\_ **Phone:** \_\_\_\_\_  
Address, City, State, Zip: \_\_\_\_\_

Name of Person Filling out Form and Title: \_\_\_\_\_



