Camp Physical Examination

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

We request this form or a copy of a physical dated no later than **12 months** from your camp date be received in our office at least **FOUR WEEKS** prior to 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:	Neck/Thyroid & Lymph Sys:
Hearing Loss: NONE PARTIAL COMPLETE Hearing Aids Worn? Cochlear Implant?	Nervous System/Reflexes/Gait/Sensations:
Vision Loss: NONE PARTIAL COMPLETE Glasses Worn? Contacts Worn?	Bringing to camp: CPAP or Oxygen (CIRCLE) DAY NIGHT (CIRCLE)
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 Frequency of glucose monitoring:	Seizures: Type: 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)**

***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 Breakfast	12:00pm Lunch	3:30pm Snack	6:00pm Dinner	8:30pm Bedtime	Other

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:_____

MEDICATION SHEET (Continued)

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