

**Physician's Section ~ Physical Exams required within 24 months of camp. Physician must complete & sign this section annually.**

I examined \_\_\_\_\_ on \_\_\_\_\_  
 Blood Pressure \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

In my opinion, the above applicant  is  is not, able to participate in an active camp program

The applicant is under the care of a physician for the following conditions:

---



---

**Medications to be administered at camp:** Place initials in yes/no box for authorization of standard over-the-counter medications to be administered at the discretion of the RN. Please write out any other **over-the-counter or prescription medications in the remaining space**. Must include medication name, route, dose, frequency, and duration to be administered at camp.

- Yes**  **No** Tylenol PO per label instructions by age/weight Q4H PRN for pain or fever > 100.5
- Yes**  **No** Ibuprofen PO per label instructions by age/weight Q6H PRN for pain or fever > 101.5
- Yes**  **No** Sudafed PO per label instructions by age/weight Q4H PRN for nasal congestion not to exceed 4 doses in 24 hours
- Yes**  **No** Ludens Throat Lozenges PO per label instructions by age/weight for cough
- Yes**  **No** Robitussin PO per label instructions by age/weight Q4H PRN for cough
- Yes**  **No** Calamine Lotion TOPICAL per label instructions for allergic reactions/pruritus
- Yes**  **No** Benadryl PO per label instructions Q6H PRN for allergic reactions

Other medications: \_\_\_\_\_

Treatments to be continued at camp: \_\_\_\_\_

Known Allergies \_\_\_\_\_

Description of any limitations or restrictions on camp activities: \_\_\_\_\_

Check box if the participant has had:

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis
- A
- B
- C

Please give dates of immunization:

VACCINE: DATES:		MO/YR	MO/YR	MO/YR	MO/YR	MO/YR	MO/YR
DPT							
TD (Tetanus/Diphtheria)							
Tetanus							
Polio							
MMR							
	Measles or						
	Mumps or						
	Rubella						
Haemophilus Influenza B							
Hepatitis B							
Varicella (Chicken Pox)							
Meningitis							
TB Mantoux Test Results		<input type="checkbox"/> Positive <input type="checkbox"/> Negative		Date last test			

Signature of Licensed Personnel: \_\_\_\_\_

Printed: \_\_\_\_\_ Title: \_\_\_\_\_

Address \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_