CAMP EAGLE HILL

Staff Healthcare Provider Form

Summer Office

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ACA Accredited

MEDICAL EXAMINATION *(to be filled in by physician)* **STAFF MEMBER'S NAME** _____

Height _____ Weight _____ BP _____ Hgb._____ Urinalysis _____

1. This individual is under the care of a physician for the following conditions:

_____

2. Please state any physical disability that this individual has: _____

3. Has this individual had any surgery? If yes, for what, and when?

_____

4. Has this individual ever had any serious illnesses? If yes, what type, and when?_____

_____

5. Has this individual had any recurring illnesses?

_____

6. Are there to be any restrictions for this individual while in camp? _____

7. Are swimming and diving permitted? _____

8. Is strenuous activity permitted? _____

9. Any additional health information or special instructions for this individual? _____

10. Any treatment to be continued at camp? _____

11. Any medically prescribed meal plan or dietary concerns? _____

12. Any special instructions for the camp? _____

I have examined _____and have reviewed his/her health history. This health history is correct so far as I know. It is my opinion that he/she is physically able to engage in all activities, except as noted above.

_____ **M.D** **Date of Form Completion** _____

EXAMINING PHYSICIAN'S SIGNATURE

~ **OVER** ~

Staff Healthcare Provider Form *continued*

MEDICAL EXAMINATION ***(to be filled in by physician)*** **STAFF MEMBER'S NAME** _____

Height _____ Weight _____ BP _____ Hgb._____ Urinalysis _____

IMMUNIZATION AND DISEASE HISTORY ***(Please give dates of immunizations from latest date, then backward in time)***

[Note: It is advisable that a Tetanus Booster be administered to provide protection throughout the camp season]

Which of the following has the participant had?

- ☐ Measles
- ☐ Chicken Pox
- ☐ German Measles
- ☐ Mumps
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Lyme Disease
- ☐ West Nile Virus
- ☐ Meningitis

PHYSICIAN: TB Mantoux Test:

Date of Last Test _____

TEST RESULTS: (check one) ☐ POSITIVE ☐ NEGATIVE

PHYSICIAN: Please give all dates of immunizations for:

VACCINE	Mo./Yr.	Mo./Yr.	Mo./Yr.
DTP	_____	_____	_____
TD (tetanus/diptheria)	_____	_____	_____
Tetanus	_____	_____	_____
Polio	_____	_____	_____
MMR	_____	_____	_____
or Measles	_____	_____	_____
or Mumps	_____	_____	_____
or Rubella	_____	_____	_____
Haemophilius Influenza B	_____	_____	_____
Hepatitis B	_____	_____	_____
Varicella (Chicken Pox)	_____	_____	_____

NON-PRESCRIPTION MEDICATIONS ***(to be filled in by physician)*** The following medications are available in the camp's Infirmary and will be administered at the discretion of a Registered Nurse if approval is indicated by the staff member's health provider.

DRUG NAME	ROUTE	DOSAGE & SCHEDULE	INDICATIONS	PHYSICIAN'S ORDER		COMMENTS
Tylenol (or generic)	PO (chewable, elixir, tabs) PR (suppository)	Per Label Instructions	Pain or Fever	YES	NO	
Ibuprofen	PO (chewable, suspension, tabs)	Per Label Instructions	Pain or Fever	YES	NO	
Robitussin (or generic)	PO (syrup)	Per Label Instructions	Cough	YES	NO	
Pepto-Bismo (or generic)	PO (liquid or chewable tabs)	Per Label Instructions	Upset Stomach Diarrhea	YES	NO	
Kaopectate (or generic)	PO (liquid or tabs)	Per Label Instructions	Diarrhea	YES	NO	
Mylanta (or generic)	PO (chewable tabs)	Per Label Instructions	Upset Stomach	YES	NO	
Chlorpheniramine Chlortrimeton	PO (tabs)	Per Label Instructions	Seasonal Allergy Symptoms	YES	NO	
Dimetapp (or generic)	PO (elixir or tabs)	Per Label Instructions	Nasal Congestions Seasonal All. Sympt.	YES	NO	
Bendaryl (or generic)	Topical ointment PO (elixir, chewable tabs/pills)	Per Label Instructions	Allergic Reactions (hives, insect bites)	YES	NO	
Antibiotic Ointments	Topical	Per Label Instructions	Superficial Cuts/ Abrasions	YES	NO	
Hydrocortisone Cream	Topical	Per Label Instructions	Allergic Reactions (bites/poison ivy)	YES	NO	
Calamine Lotion (or generic)	Topical	Per Label Instructions	Allergic Reactions (bites/poison ivy)	YES	NO	

ADDITIONAL ORDERS ***(as deemed necessary by health care provider, to be implemented by RN)***

_____

MEDICATIONS TO BE TAKEN AT CAMP ***(to be filled in by physician)***

_____

Physician's Signature_____ Physician's Phone Number ( ) _____