

# 2017 Camp Eagle Hill Medical Form (PHYSICIAN FORM)

## MEDICAL EXAMINATION (to be filled in by physician)

CAMPER'S NAME \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ Hgb. \_\_\_\_\_ Urinalysis \_\_\_\_\_

1. This child is under the care of a physician for the following conditions:  
\_\_\_\_\_
2. Please state any physical disability that this child has: \_\_\_\_\_
3. Has this child had any surgery? If yes, for what, and when?  
\_\_\_\_\_
4. Has this child ever had any serious illnesses? If yes, what type, and when? \_\_\_\_\_  
\_\_\_\_\_
5. Has this child had any recurring illnesses?  
\_\_\_\_\_
6. Are there to be any restrictions for this child while in camp? \_\_\_\_\_
7. Are swimming and diving permitted? \_\_\_\_\_
8. Is strenuous activity permitted? \_\_\_\_\_
9. Any additional health information or special instructions for this child? \_\_\_\_\_
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.***

**Date of Form Completion** \_\_\_\_\_

\_\_\_\_\_  
*Examining Physician's Signature*

M.D

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

Please list all medications, including all over-the-counter or non-prescription drugs, taken routinely or as needed (PRN). Please send along enough medication for your child's session of camp. In addition, please keep any medication in original packaging so that the original bottle can identify the prescribing physician. (in the case of prescription medication) This will allow us to see the name of the medication, the dosage to be taken, and the frequency of administration.

**MEDICATION #1:** \_\_\_\_\_ **Dosage** \_\_\_\_\_ **Specific Times Taken Each Day** \_\_\_\_\_

***Reason For Taking*** \_\_\_\_\_

**MEDICATION #2:** \_\_\_\_\_ **Dosage** \_\_\_\_\_ **Specific Times Taken Each Day** \_\_\_\_\_

***Reason For Taking*** \_\_\_\_\_

**MEDICATION #3:** \_\_\_\_\_ **Dosage** \_\_\_\_\_ **Specific Times Taken Each Day** \_\_\_\_\_

***Reason For Taking*** \_\_\_\_\_

**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: Please give all dates of immunizations for:****VACCINE**Mo./Yr.Mo./Yr.Mo./Yr.

DTP

TD (tetanus/diphtheria)

Tetanus

Polio

MMR

or Measles

or Mumps

or Rubella

Haemophilus Influenza B

Hepatitis B

Varicella (Chicken Pox)

**PHYSICIAN: TB Mantoux Test:**

Date of Last Test: \_\_\_\_\_

[TEST RESULTS: (circle one)]

POSITIVE    NEGATIVE

**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 camper's health provider.

DRUG NAME	ROUTE	DOSAGE and 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 Congestion Seas. All. Sympt.	YES    NO	
Benadryl (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 (hives, bites)	YES    NO	

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

(

\_\_\_\_\_  
Physician's Phone Number