CAMP EAGLE HILL

2024 Staff Medical Form (Physician Form)

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ACA Accredited

STAFF MEMBER'S NAME _____

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

Height _____ Weight _____ BP _____ Hgb._____ Urinalysis _____

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

Date of Form Completion _____

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 bring along enough medication for the stay 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 _____

~ OVER ~

2024 STAFF Medical Form (Physician 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?

- ☐ **POSITIVE DIAGNOSIS for COVID-19 date diagnosed** _____
- ☐ 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)			

COVID-19 Vaccine

initial vaccine: mo./day/yr. _____ second vaccine: mo./day/yr. _____
Booster mo./day/yr. ____ Booster m/d/yr._____ Updated Booster m/d/yr. ____

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 & 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)***

_____

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