

CAMP EAGLE HILL

CAMPER'S NAME _____

Date of Birth: / /

2026 Camper Medical Form (Physician Form) - PAGE 2

Gender: male female other

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

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]

<p>Which of the following has the participant had?</p> <p><input type="checkbox"/> COVID-19 - when last? month/year _____</p> <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Chicken Pox</p> <p><input type="checkbox"/> German Measles</p> <p><input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Hepatitis A</p> <p><input type="checkbox"/> Hepatitis B</p> <p><input type="checkbox"/> Hepatitis C</p> <p><input type="checkbox"/> Lyme Disease</p> <p><input type="checkbox"/> West Nile Virus</p> <p><input type="checkbox"/> Meningitis</p> <p>PHYSICIAN: TB Mantoux Test: Date of Last Test _____</p> <p>TEST RESULTS: (check one) <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE</p>	<p>PHYSICIAN: Please give all dates of immunizations for:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">VACCINE</th> <th style="text-align: center;">Mo./Yr.</th> <th style="text-align: center;">Mo./Yr.</th> <th style="text-align: center;">Mo./Yr.</th> </tr> </thead> <tbody> <tr><td>DTP</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>TD (tetanus/diphtheria)</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Tetanus</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Polio</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>MMR</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>or Measles</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>or Mumps</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>or Rubella</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Haemophilus Influenza B</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Hepatitis B</td><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>Varicella (Chicken Pox)</td><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table> <p>Covid - 19 vaccines initial: mo./day/yr. ____ Second: mo./day/yr. ____ Booster mo./day/yr. ____ Booster mo./day/yr. ____ Update mo./day/yr. ____</p>	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)	_____	_____	_____
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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 () _____