Applicant Name: _____ Date of Birth: _____/_____/_____

☐ July ☐ August ☐ Full Summer

PHYSICIAN'S EXAMINATION

This examination should be completed within 12 months prior to the camper's arrival. An examination conducted for another purpose within this time frame is acceptable. This assessment is intended to determine fitness for participation in strenuous camp activities.

Height: _____ Weight: _____ Heart: _____ Blood Pressure: _____

Hct/Hgb Test (if appropriate): _____ Urinalysis: _____

HEALTH ASSESSMENT

Please rate each item using the following scale: *V- Satisfactory X- Not satisfactory O- Not examined*

_____ Eyes _____ Ears _____Nose _____Throat _____Extremities _____Glasses

_____Lungs _____ Genitalia _____Abdomen _____Hernia _____ Posture _____ Skin

Date of Last Tetanus Shot: ___/___/_____ Are immunizations up to date? ____Yes ____ No

General Appraisal *Please address any concerns from above*_____

_____

Allergies: *Please list any allergies the applicant may have including food, insects, medicine, seasonal/ environmental.* _____

_____

Recommendations: *List restrictions on the applicant at camp including: special diets, current medications, swimming, diving, strenuous activities.* _____

_____

I have examined the person herein described and have reviewed the health history. It is my opinion that this person is physically able to engage in camp activities, except as noted above.

I examined the applicant today ☐Yes ☐No If no, date of examination: _____

_____	_____	_____
Name of Provider	Signature	Date

Contact information: _____

Over-the-Counter (OTC) Medication Authorization & Meningitis Form

Camper Information:

Full Name: _____ Date of Birth (MM/DD/YYYY): ____ / ____ / _____

Parent/Guardian Name: _____ Parent/Guardian Contact Number: _____

Authorized Over-the-Counter Medications: Please indicate which OTC medications the camper is authorized to receive during camp, as needed, by checking the appropriate boxes.

Pain Relief/Fever Reduction:
☐ Acetaminophen (e.g., Tylenol)
☐ Ibuprofen (e.g., Advil, Motrin)

Allergy Relief:
☐ Diphenhydramine (e.g., Benadryl)
☐ Loratadine (e.g., Claritin)

Decongestants:
☐ Pseudoephedrine (e.g., Sudafed)
☐ Phenylephrine (e.g., Sudafed PE)

Gastrointestinal Relief:
☐ Antacid (e.g., Tums)
☐ Loperamide (e.g., Imodium)
☐ Polyethylene Glycol 3350 (e.g., MiraLAX)

Topical Applications:
☐ Hydrocortisone Cream 1%
☐ Triple Antibiotic Ointment (e.g., Neosporin)
☐ Calamine Lotion
☐ Sunscreen
☐ Insect Repellent

Cough/Cold Relief:
☐ Cough Drops
☐ Guaifenesin (e.g., Robitussin)

☐ **ALL OTC MEDICATIONS LISTED**
Other (please specify)_____

Administration Instructions: All medications will be administered according to package directions unless the healthcare provider specifies otherwise below. Specific instructions if any: _____

☐ I give permission for my daughter to keep her sunscreen & insect repellent in her room and apply them as needed.

☐ **Parent/Guardian Authorization:** I hereby authorize the designated camp personnel to administer the above-listed over-the-counter medications to my child as specified. I understand that these medications will be administered according to the package directions unless otherwise instructed by the healthcare provider.

Healthcare Provider Authorization: As the camper's licensed healthcare provider, I confirm that the above-listed over-the-counter medications are appropriate for this camper and may be administered by camp personnel as specified.

Provider Name (Printed): _____ Provider Signature: _____

Date: ____ / ____ / _____ Provider License Number: _____

Provider Phone #: _____

Additional Notes or Special Instructions:_____

Meningitis Information

Please complete the following section, even if your child has been immunized:

____My child has received the meningococcal meningitis immunization (Menomune™) within the past 10 years.

Date immunization was received: _____
(Note: The vaccine's protection lasts approximately 3 to 5 years. Revaccination should be considered within this timeframe.)

☐ I read and understood the information regarding meningococcal meningitis disease. My child will obtain immunization against meningococcal meningitis from my healthcare provider within 30 days.

☐ I read and understood the information regarding meningococcal meningitis disease. I have decided that my child will not obtain immunization against meningococcal meningitis disease.

Parent/Guardian Signature: _____Date: ____ / ____ / _____