Lions Camp Horizon Physical Examination Form

Please note: This form must be completed & returned as soon as possible, no later than June 1st. Please set up an appointment now to avoid delays.
Campers will not be admitted without a completed Physical Examination Form & current list of medications from their healthcare provider.

Section 1 – Personal Information (To be completed by parent/guardian)

Camper's Full Name: _____ DOB: _____ Male_____ Female_____

Parent/Guardian Name: _____ Phone: _____ Email:_____

Section 2 – Medical Information (To be completed by healthcare provider)

Height: _____ Weight: _____ Blood Pressure: _____ Heart Rate: _____ Temp: _____

Assessment: Please circle any areas of concern or that require attention/treatment. Please provide details in the space below

Skin/Scalp Eyes Ears Nose/Throat Mouth/Teeth Glands Lungs Heart Abdomen

Notes:_____

Allergies: Does camper have any medication, environmental, food or insect/animal allergies? **YES NO** Require Epi-Pen? **YES NO**
Please provide details on any allergies including allergy type, severity, reaction and treatment:

_____

_____

Other Medical Information:

Primary Diagnosis: _____

Chronic/Recurring Medical Conditions or Injuries: (Please note signs to watch for and treatment) _____

_____

Does camper have any physical restrictions when participating in camp activities such as sports, dancing, walks, games, etc.?

_____

Does camper have any medically prescribed dietary restrictions, food allergies or specific meal plans? Please include gluten intolerant/celiac, lactose intolerant, sugar free/diabetic, food allergies/reactions, other. **YES NO**

Provide details including severity, reaction and treatment.

_____

_____

Does camper use any of the following (Circle all that apply)**: Rescue Inhaler Oxygen Tank CPAP/VPAP Cane/Walker Wheelchair Gait Belt Colostomy Bag Catheter Prosthetics Orthotics Feeding Tube Communication Device**

Please list any other medical devices or assistance equipment we should be aware of:

_____

Does Camper have a history of seizures? **YES NO** If yes, date of last seizure: _____ Please advise type, frequency & signs to watch for:_____

Vaccinations:
Date of last Tetanus vaccine: _____ Date of last TB test: _____ **POSITIVE NEGATIVE**
Date of last COVID vaccination: _____ Is camper fully vaccinated for COVID per WA State definition? **YES NO**

Please provide any additional information our nursing staff should be aware of:

_____

_____

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Section 3 – Medications (To be completed by healthcare provider)

Please Note: No prescription medication or over the counter medication will be dispensed to the camper without the signature of a licensed health care provider. Please provide a complete list of all prescribed and over the counter medications/supplements. This list must include medication name, dosage and time to be administered. The information on the medication list must match the labels on the medication packaging. All medication must be in original packaging or pre-packed in bubble packs by a pharmacy. DO NOT USE SELF FILLED PILL BOXES.

Please complete the section below with ALL prescription medications, over the counter medications and supplements that are to be administered at camp. Medications are administered at the following times: 8 am (Breakfast), Noon (Lunch), 5 pm (Dinner), and 8 pm (Before Bedtime). Please specify any need for exceptions to these times.

Medication List (You may provide a printout with the medication information. Please ensure it includes the campers full name, all medications, dosages and times)

Medication Name	Dosage	Time to be Administered (Circle all)	Notes
		8 am 12 pm 5 pm 8 pm Other_____	
		8 am 12 pm 5 pm 8 pm Other_____	
		8 am 12 pm 5 pm 8 pm Other_____	
		8 am 12 pm 5 pm 8 pm Other_____	
		8 am 12 pm 5 pm 8 pm Other_____	
		8 am 12 pm 5 pm 8 pm Other_____	
		8 am 12 pm 5 pm 8 pm Other_____	
		8 am 12 pm 5 pm 8 pm Other_____	
		8 am 12 pm 5 pm 8 pm Other_____	
		8 am 12 pm 5 pm 8 pm Other_____	
		8 am 12 pm 5 pm 8 pm Other_____	

Over the Counter Medication Authorization

I authorize the use of the following OTC medications to be used for their intended purpose as needed. (Please check all approved)

- ☐ Acetaminophen 325 mg 1-2 tabs or liquid equivalent. For headache, pain, menstrual cramps or fever over 100.5
- ☐ Ibuprofen 200 mg 1-2 tabs or liquid equivalent. For headache, pain, menstrual cramps or fever over 100.5
- ☐ Diphenhydramine 25 mg 1-2 tabs or liquid equivalent. For itching, rash or allergic reaction
- ☐ Non-narcotic cough suppressant/expectorant 2 tsp (10cc). For cough
- ☐ Cough drops 1 lozenge. For cough or sore throat (Max of 10/24 hours)
- ☐ Pseudoephedrine HCL 30 mg, 2 tabs. For nasal congestion due to colds or sinusitis
- ☐ Alum/Magnesium Hydroxide liquid w/simethicone 2 tbsp (30cc)
- ☐ Pepto Bismol 2 tbsp (30cc)/Tums 1-2 tablets
- ☐ Simethicone 1-2 tabs after meals. For gas (Max of 4/24 hours)
- ☐ Milk of Magnesia 2 tbsp (30cc) Followed by 8 oz of water for constipation.
- ☐ Kaopectate 2 tbsp (30cc) For diarrhea. Once dose after each loose bowel movement. (Max of 8 tbsp/24 hours)
- ☐ Loperamide HCL liquid 4 tsp (20cc) for first loose bowel movement & 2 tsp (10cc) after each additional (Max 8 tsp/24 hours)
- ☐ Visine eye drops or similar product 1-2 drops per eye. For redness or itching.
- ☐ Bacitracin as needed for minor abrasions
- ☐ Antibiotic cream as needed for minor abrasions
- ☐ Hydrogen Peroxide as needed for cleaning minor cuts and abrasions
- ☐ Betadine solution as needed for wound disinfection, abrasions and lacerations
- ☐ Dermoplast spray as needed for relief of minor burns
- ☐ Chapstick or Vaseline as needed for chapped lips
- ☐ Sunscreen SPF 30 or higher as needed
- ☐ Insect repellant as needed

Signature of licensed practitioner completing the Health Examination Form:____

Printed name: ____ Date: ______________________________

Telephone number: ____