TAPAWINGO PHYSICAL EXAMINATION FORM 2018

Speculator, NY 12164

This form is to be completed and signed by a Licensed Medical Provider. A physical is required within one year of the camper session.

Camper Name:_____ **Date of Physical**:_____

DOB:_____ **B/P**:_____ **Weight**:_____ **Height**:_____

Additional Information for Health Care Staff:_____

_____

IMMUNIZATION HISTORY – attach a copy of immunizations. A legal waiver must be signed for conscientious exemption (A NY State Immunization Exemption form can be filled out on your daughter's profile online)

Medical History:

- ❒ No Health Concerns
- ❒ Anxiety
- ❒ Asthma
- ❒ ADHD, ADD
- ❒ Bone, Muscle Injury
- ❒ Depression
- ❒ Eating Disorder
- ❒ Seizure Disorder
- ❒ Sleep Problems
- ❒ Headaches/Migraines
- ❒ Head Injury/Concussion
- ❒ Diabetes (MD signature is required on a Diabetic Care Plan)
- ❒ Other:

Current Treatment:_____

Dietary Restrictions/Meal Plan:_____

Allergies – please describe reactions and management

❒ No Known Allergies

ALLERGEN	TREATMENT	ANAPHYLAXIS?
❒ Food:		
❒ Medication(s):		
❒ Insect Stings:		
❒ Other:		

In my opinion, this camper is fit for a very active wilderness camp, which includes, but is not limited to: hiking, water sport activities and navigating outdoor terrain on an island.

❒ Yes ❒ No

MEDICATION ADMINISTRATION AUTHORIZATION

New York State Law requires a physician's signature for any medication to be dispensed by the Camp Health Director. No medications will be given unless signed off by your physician.

New York State requires all prescription AND over-the-counter medications that are taken regularly by a camper to be listed on this form. This includes creams, supplements, vitamins, and essential oils.

DIAGNOSIS	MEDICATION	DOSAGE	FREQUENCY

OVER-THE-COUNTER MEDICATIONS The following non-prescription medications are stocked in the Camp Health Center and are given by the Health Director, on an as needed basis. Please **DO NOT** send any of the following to camp (except for sunscreen). All medications will be dispensed per manufacturer's recommended dosage/schedule and as appropriate by age/weight.

MEDICAL PERSONNEL ONLY: All of the following may be given unless otherwise noted. Please verify with parents when selecting yes or no for each OTC medication.

MEDICATION	YES	NO
Acetaminophen (Tylenol)		
Ibuprofen (Advil, Motrin)		
Dextromethorphan & Guafenesin (Robitussin DM)		
Cough Drops		
Diphenhydramine (Benadryl)		
Phenylepherine Decongestant (Sudafed PE)		
Day-Time Cold Capsules (DayQuil)		
Night-Time Capsules (NyQuil)		
Dimaphen DM (Dimetapp Cough and Cold)		
Chloraseptic Throat Spray		
Vitamin C		
Dramamine		
Immodium AD		
Tums		
Pepto-Bismol		
Laxatives (Milk of Magnesia, Senna or Bisacodyl)		
Triple Antibiotic Ointment (Neosporin/Bacitracin)		
Calamine Lotion		
Aloe/Silvadene Cream/Burn Gel		
Muscle Rub (Bengay)		
Hydrocortisone Cream		
Visine		
Orajel		
Lice Shampoo (Nix)		
Auro-Dri (Swimmer's Ear)		
Albuterol Inhalation Solution 0.083% via SVN		
Zyrtec		
Claritin		
Allegra		
Sunscreen		
Other:		

I have examined the patient herein described and have reviewed the health history.

Licensed Medical Provider Signature:_____**Date:**_____

Physician Name (print):_____**Phone Number:**_____

Address:_____