TAPAWINGO
Place of Joy

TAPAWINGO PHYSICAL EXAMINATION FORM 2019

Speculator, NY 12164

This form is to be completed and signed by a Licensed Medical Provider.

Staff 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 (NY State Immunization Exemption form can be filled out on your online profile).

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 person 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 staff member 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** bring any of the following to camp. **MEDICAL PERSONNEL ONLY**: All of the following may be given unless otherwise noted. Please verify with patient when selecting yes or no for each OTC medication.

MEDICATION	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	
Calamine Lotion	
Burn jel	
Aloe	
Muscle Rub (Bengay)	
Hydrocortisone Cream	
Visine	
Orajel	
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:_____