Camper Name _____

Physical Examination

MUST BE SIGNED BY PARENT/GUARDIAN BELOW BEFORE SUBMITTING TO PHYSICIAN

I give permission to the Medical Office named below to release information requested on this form to Rotary Camp Haccamo along with any other medical information relevant to the care of my child during his/her time at Camp Haccamo. I give permission for this form and medication order forms to be faxed or mailed to Rotary Camp Haccamo upon request. I understand that this information will be kept confidential and will be used only as previously indicated.
Parent/Guardian Signature _____ Date: _____

DOB_____ Primary MD _____ Phone: _____

Diagnosed Disability *(documentation of disability must be included) _____Medical History of serious illness/injury: _____

_____

Does this individual have a Seizure Disorder or History of Seizures? Y/N

Allergies: _____

PHYSICAL EXAM Height_____ Weight _____ Pulse _____ Resp._____ Blood Pressure: _____

Sensory Impairments:

Vision _____ RT _____ LT_____ Genitourinary:_____

Hearing _____RT_____ LT_____ Respiratory: _____

Speech _____ Fine/Gross Motor: _____

Cardiovascular: _____ Scoliosis: _____

Gastrointestinal: _____ Metabolic/Endocrine: _____

Neurological: _____ Skin: _____

Adaptive Devices (specify): _____

Progressive Impairments: _____

Restrictions of Physical Activity/Swimming: _____

Medications (*Include dose, times*)_____

Special Diet: _____

Immunization Status:

	1st	2nd	3rd	4th	Booster
DPT					
Td					
OPV/IPV					
Measles					
Mumps MMR					
Rubella					
Hep B					
HIB					
Varivax					

Tuberculin Test Date: _____ Results:_____

DATE OF EXAM _____REQUIRED OR APPLICATION WILL NOT BE ACCEPTED

Physician Signature:_____ Printed Name of Physician:_____

Address: _____ Phone:_____

Camper Name_____ DOCTOR'S ORDERS

Medicine: to be brought to camp by the parent/guardian in **original** container. *If more space is needed, please attach an additional sheet.*

Please print legibly – Please indicate how medication is taken (i.e. in applesauce)_____

Medication/strength _____Dosage_____Time_____

Medication/strength _____Dosage_____Time_____

Medication/strength _____Dosage_____Time_____

Medication/strength _____Dosage_____Time_____

Medication/strength _____Dosage_____Time_____

Medication/strength _____Dosage_____Time_____

Medication/strength _____Dosage_____Time_____

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Medication/strength _____Dosage_____Time_____

Medication/strength _____Dosage_____Time_____

Over the Counter Medication – MANDATORY – THIS SECTION NEEDS TO BE COMPLETED!!

Administration will be "per label direction" unless otherwise specified by your physician.

Drug Name	**Provider Order**	**Physician's Comments**
Tylenol (discomfort/fever)	YES/NO	_____
Advil (discomfort/fever)	YES/NO	_____
Throat Lozenges (throat irritation/cough)	YES/NO	_____
Benadryl (allergies)	YES/NO	_____
Cortizone Cream (topical)	YES/NO	_____
Milk of Magnesia (constipation)	YES/NO	_____
Immodium AD (diarrhea)	YES/NO	_____
Maalox (stomach upset)	YES/NO	_____
Tums (heartburn/stomach upset)	YES/NO	_____
First Aid Cream/Neosporin	YES/NO	_____

NOTE: If there is any change in routine or in medication subsequent to the filling out of this form, the camp must receive **WRITTEN NOTIFICATION FROM THE PHYSICIAN**.

Physician's Signature: _____ Date: _____

Printed Name of Physician: _____

FAMILY OR AGENCY MUST PICK UP THIS FORM FROM PHYSICIAN'S OFFICE AND REVIEW MEDICATION ORDERS PRIOR TO CAMPER'S ATTENDANCE AT CAMP

Medical History Form
MUST be completed by Parent/Guardian

Camper Name: _____ DOB: _____Sex:_____

Important: The entire form must be completed for the application to be processed. This includes emergency contact information. Non-applicable fields can be marked N/A. Campers under 18 MUST have a physical within one year of date of attendance.

Parent/Guardian: _____ Ph:_____ Wk:_____ Cell_____
Parent/Guardian Address:_____

Parent/Guardian: _____ Ph:_____ Wk:_____ Cell_____
Parent/Guardian Address:_____

Emergency Contact: _____ Ph:_____ Wk:_____ Cell_____

Health History- Fill in all that apply with appropriate date
Frequent ear infections_____
Psychiatric Treatment:_____
Heart Defect/Disease _____**Seizures**: _____
Chicken Pox_____ Diabetes: _____
Bleeding/Clotting: _____ Disorders: _____

Hypertension:
_____

Please list any known allergies
_____
_____
_____
_____

DIAGNOSED DISABILITY:_____
Allergies: _____

Surgeries/Serious Injuries: _____
Dietary Modifications:_____

Has the camper ever required psychiatric counseling or hospitalization? If so, please explain briefly.
_____

FOR FEMALE CAMPERS: Has the camper begun a menstrual cycle? Y/N If so, is her menstrual cycle normal? Y/N If no, please explain and list any special considerations
_____

Please provide the following information:
Primary Physician _____ Phone_____Physician's After hours phone:_____
Date of last physical _____
Dentist/Orthodontist _____ Phone: _____
Do you carry medical/hospital insurance? _____ Carrier:_____Policy Number: _____

Must be signed by parent or guardian
This health history is accurate to my knowledge. The camper named above has permission to engage in all camp activities except as noted. I hereby give Rotary Camp Haccamo permission to provide ongoing health care, to select medical personnel, and to order x-rays or routine medical tests and treatment as deemed necessary. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Manager to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the camper named above. This form may be photocopied for use by Camp Haccamo.
Parent/Guardian Signature: _____ Date: _____