

**YOUTH CAMP HEALTH EXAM/RECORD
FOR CAMPERS AND STAFF**
Physical Exams Are Valid For 3 Years
From Date of Last Examination

Camper
 Staff

Please Return Completed Form to the Camp

Name _____ Date of Birth _____ Phone _____
Guardian _____ Address _____
Emergency Contact _____ Telephone _____
Date of Arrival at Camp: _____ Departure Date: _____

TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:

Date of Exam _____ / _____ / _____

_____ May participate in all camp activities
_____ May participate except for: _____

Medical information pertinent to routine care and emergencies: _____

Is this individual taking prescription or over the counter medication(s)? YES NO If yes, indicate names of medication(s): _____

Does the individual have allergies? YES NO Explain: _____

Is the individual on a special diet? YES NO Explain: _____

Does the individual have special needs? YES NO Explain: _____

This camper/staff is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		

Comments: _____

Print name of medical care provider: _____

Medical care provider's address: _____

Medical care provider's: City/Town _____ ST _____ Zip Code _____

Signature of Physician, PA, APRN or RN

Date Form Signed

Telephone Number

SELF ADMINISTRATION AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS

No Medication, prescription or nonprescription shall be administered to a child without the order of an authorized prescriber and the written permission of the child's parent which shall be kept on file at the child care center. Such medications may include:

1. Oral medications;
2. Topical medications, including eye and ear preparations;
3. Inhalant medications; and
4. Injectable medications, by a premeasured, commercially prepared syringe, to a child with a medically diagnosed condition who may require emergency treatment

AUTHORIZED PRESCRIBER ORDER (Physician, dentist, advanced practice registered nurse, physician assistant, optometrist or podiatrist)

Name of child _____ Date _____

Address _____ Date of Birth _____

Condition for which drug is being administered at the child care center _____

Name, dose, time, method of administration (see above) _____

Medication shall be administered from _____ to _____
(start) (end)

Relevant side effects to be observed, if any _____

If there are side effects the plan for management _____

Is this a controlled drug? _____ Allergies to food or drugs? If yes list _____

Authorized Prescriber's Name _____ Telephone _____

Address _____

****I hereby request that the above child has my permission to self administer the above medication. I understand that the child may receive assistance from the staff in opening containers or packages or replacing lids. This child is able to identify and select the appropriate medication by size, color, amount or other label identification. They also know the frequency and time of day for which their medication is ordered and can consume the medication appropriately**

Authorized Prescriber's Signature _____ Date _____

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION:

To child center staff: I hereby request that the above medication, ordered by the authorized prescriber for my child _____, may be administered by **my child. As the parent/ guardian of the child it is my responsibility to supply the child care center with the prescribed medication in the original child resistant safety container dispensed and properly labeled by a physician or pharmacist.

I understand that this medication will be destroyed if it is not picked up one week following the expiration date of this form.

I have administered at least one dose of the above medication to my child without adverse side effects.

Please circle: Yes or No

Name: _____ Date: _____

Address _____ Telephone: _____

Signature: _____ Relationship to child: _____
