Medical Evaluation

Camper Name _____Date of birth___/___/___has had a complete history & physical exam on __/____/____

(American Camp Association accreditation requirements specify exams within 12 months of camp attendance. A new exam is not necessarily required for camp attendance.)

Height:	BMI:	Vision/Type of Screening
Weight:	☐ Normal	With glasses R 20/ L 20/
Blood Pressure:	☐ Abnormal	Without glasses R 20/ L 20/
Pulse:		
HCT/Hgb:	TB: In high risk group? ☐Yes ☐ No	Auditory/Type of Screening
Urinalysis:	TB & other Test Results (sickle Cell, etc)	Right Pass/Fail
Gross Dental:		Left Pass/ Fail
Lead (Date/Result)		

Yes	No	To What:	Date of Onset
☐	☐ Asthma	☐ Mild ☐ Moderate ☐ Severe ☐ Exercise Induced ☐ Unclassified	
☐	☐ Diabetes	☐ Type I ☐ Type II	
☐	☐ Anaphylactic Reaction	☐ Food ☐ Insect ☐ Latex ☐ Other: Explain	
☐	☐ Seizure Disorder	Type:	
☐	☐ Chicken Pox	If yes, when?	
☐	☐ Mumps	If yes, when?	
☐	☐ Other: Please Specify		

DPT/Hib					
DTaP					
DT/Td					
OPV					
IPV					
MMR					
HiB					
Hep B					
Hep A					
Varicellla					
TDap					
PCV					
HPV					
MCV					
Influenza					

Please Record Immunization Dates on Page 3. A copy of a current immunization record is acceptable.

Camper Name _____ Date of Birth: _____

The following Standard "Over the Counter" PRN Medications are available in the Health Center to be administered per package instructions unless otherwise specified by the family physician.

This page must be completed by the Physician. Please cross out any OTC medications not desired for this camper.

Drug Generic equivalents may be used	Route	Dosage	Schedule	Indications	Comments
Diphenhydramine	PO	____MG ____ML	Q_____HRS	Insect Bites, Allergies	
Tums	PO	____MG ____ML	Q_____HRS	Indigestion	
Acetaminophen	PO	____MG ____ML	Q_____HRS	Pain, Fever	
Ibuprofen	PO	____MG ____ML	Q_____HRS	Pain, fever	
Hydrocortisone Cream	Topically	____MG ____ML	Q_____HRS	Insect bites, rash	
Cough Drops	PO	____MG ____ML	Q_____HRS	Cough, sore throat	
Antibiotic Cream	Topically	____MG ____ML	Q_____HRS	Cuts, scrapes	

Non Prescription and Prescription Medications (Please complete with patient's current regimen for both scheduled and prn medications. Use 2nd page if needed) this includes vitamins, inhalers, ear and eye drops. ***Medications must be in the original labeled bottle with directions for administration.***

Drug	Route	Dosage	Schedule and Indications	Comments

I certify that I have on this date examined the above named camper and that on the basis of my examination and the medical history as furnished to me, I have found no reason which would make it medically inadvisable for this camper to participate in physically strenuous activities.

Signature of Physician _____ Date of Examination _____

Please Print: Physician's Name _____ License # _____
Address _____ Phone # _____