IdRaHaJe

PHYSICAL FORM (Due 1 week before camp)

Camper Name: _____

Camp & Week Attending: _____

Year: _____

CAMPER'S PHYSICAL FORM: To be filled out by the doctor

Medical condition(s) Camp should be aware of: _____

Special instructions (e.g., special diets, exempted activities, etc.): _____

Allergies (e.g., drugs, food, other): _____

Camper's biological sex: **M / F**

Does this camper regularly take prescription medications, OTC medications, or vitamins? **Yes / No**

(If yes, please fill out the attached Medication Form with correct dosage and frequency)

_____ was given a camp physical examination on ___/___/___. (Must be within 24 months of designated Camp.) S/he is in satisfactory physical condition and capable of active participation except as noted above.

Signature of Doctor _____ **Date** _____ **Phone** (___) _____

Printed Name _____ Address _____ City _____ State ____ Zip _____

PRN Prescription for OTC Medications: To be filled out by the doctor

Must be completed by prescribing health care professional.

Physicians: Please initial each medication and dosage that you approve and prescribe PRN.

******If the child has prescribed medications or requires changes to the following medications, please fill out the attached Medication Form.

This camper may receive the following OTC medications and dosages:

___ Zyrtec (Cetirizine) or Claritin (Loratadine) - 10 mg q24h PRN for itching/seasonal allergies

___ Benadryl (Diphenhydramine)- 12.5-25mg q4-6h PRN for itching/allergic reaction

___ Chlor-tab (Chlorpheniramine)- Children 6-12 yr: 2mg q4-6h PRN; Children >12 yr: 4 mg q4-6h PRN for itching/seasonal allergies/ allergic reaction

___ Tylenol (Acetaminophen)- 15mg/kg q4-6h PRN for fever and/or pain

___ Motrin (Ibuprofen)- 10mg/kg q6h PRN for fever and/or pain

___ TUMS (Calcium Carbonate)- 500-1,000 mg/day PRN for upset stomach/indigestion

___ Throat Lozenges- 1 lozenge q3-4h PRN for sore throat and/or cough

___ Triple Antibiotic Cream- 1 application PRN for cuts/scrapes

Signature of Doctor _____ **Date** _____ **Phone** (___) _____

Printed Name _____ Address _____ City _____ State ____ Zip _____

IdRaHaJe MEDICATION FORM (Due 1 week before camp)

Camper Name: ______________________
Camp & Week Attending: ______________
Year: ______________________________

This form must accompany all prescriptions, OTC medications, homeopathic remedies, essential oils and vitamins in their **original container and box** and must include the signature of the child's doctor.

______________________________ ________________________________ ___________
Parent/Guardian Printed Name Signature Date

NOTES:	CAMP MEDICAL STAFF SIGNATURE:
	X

DOCTOR MUST LIST ALL MEDICATIONS BELOW, INCLUDING: ***PRESCR., OTC, VITAMINS, ETC.***

LIST Rx: *eg. Clarinex D tab*
Med:
Dosage/Route:
Time:
To Treat What?
Contraindications:

↓CAMP PERSONNEL↓

	SUN	MON	TUE	WED	THU	FRI
8am						
12pm						
6pm						
Bedtime						

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6pm						
Bedtime						

PRESCRIBING DOCTOR'S SIGNATURE:

x Date Phone ( )
Printed Name Address City State Zip

Please use additional forms if necessary.