IdRaHaJe
PHYSICAL FORM (Due 1 week before camp)

IdRaHaJe Office Use:
Camp Session & Week_____
Year_____

To be filled out by a doctor, physician's assistant or nurse practitioner.
(Exam must take place within 24 months of designated camp session to be valid.)

Camper First and Last Name: _____

Date of Birth (Month/Day/Year): _____ **Date of Exam:**_____

Camper's biological sex: M / F

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

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

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

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.)

Please mark each medication and dosage that you, the health care professional, approve and prescribe PRN for the camper to be given by approved camp staff.

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

This camper may receive the following OTC medications and dosages while at camp:

___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

The camper listed at the top of this form is in satisfactory physical condition and capable of active participation in an overnight summer camp experience except as noted above.

Signature of Doctor_____ **Date**_____ **Phone**(____)_____

Printed Name_____ Address_____ City_____ State_____ Zip_____

IdRaHaJe MEDICATION FORM (Due 1 week before camp)

IdRaHaJe Office Use:
Camp Session & Week___________________
Year__________

Camper Name: ______________________________
Date of Birth: ________________________________

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*	↓CAMP PERSONNEL↓		SUN	MON	TUE	WED	THU	FRI
Med:								
Dosage/Route: Time:		8am						
To Treat What?		12pm						
Contraindications:		6pm						
		Bedtime						

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★**Prescribing Doctor's Signature:**____ **Date:**___________

Printed Name:____________________________________ **Phone:** ________________________

Address:____