



CAMP PHYSICAL FORM 2023

CAMPER NAME: _____ DOB: _____

The following must be completed by a licensed medical provider. Vaccination history, including COVID-19 vaccination, should be uploaded into the camp system or attached.

HEALTH EXAMINATION/FINDINGS:

I have examined the applicant. Date of examination: _____ (Exam must be dated after 7/31/22.)

BP: _____ Weight: _____ Height: _____

In my opinion, the above applicant is is not able to participate in an active camp program, including swimming.

Does this child have any dietary restrictions, physical limitations, developmental/learning delays? yes no

If yes, please explain: _____

The applicant is under the care of a physician for the following conditions:

Current treatment to be continued at camp includes:

Is the applicant "up to date" on his/her immunizations? Yes No (Vaccination record to be attached.)

ROUTINE MEDICATIONS TO BE ADMINISTERED AT CAMP: Medication list may be attached to this form in lieu of completing grid below, but must also be signed by licensed provider. **Check here if no routine medications.**

| Name of Medication | Purpose | Dosage | When to administer |
|--------------------|---------|--------|--------------------|
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OTHER AUTHORIZED MEDICATIONS:

As this child's healthcare provider, you authorize that **unless otherwise noted in "Remarks" section below**, the medications listed below can be dispensed at the discretion of medical personnel at camp per dosage, schedule, and route indicated on the label.

| Name of Medication | Purpose | Remarks | Name of medication | Purpose | Remarks |
|---------------------------|--|---------|------------------------------|--|---------|
| Tylenol (or generic) | pain or fever | | Antibiotic Ointment | superficial cut/abrasion | |
| Pepto-Bismol (or generic) | upset stomach, diarrhea | | Lice shampoo/cream | lice | |
| Benadryl (or generic) | allergic reaction (hive, insect bites) | | Ibuprofen (or generic) | pain or fever | |
| Claritin (or generic) | nasal decongestant | | Calamine Lotion (or generic) | allergic reaction (contact dermatitis) | |

I certify that the medical history of this child is correct, and that she/they has medical clearance to engage in all activities, except for those noted on this form. I authorize that (unless otherwise noted in "Remarks" above) medications listed under Other Authorized Medications section can be dispensed at the discretion of medical personnel at camp per dosage, schedule, and route indicated on the label.

Signature of Licensed Medical Personnel _____ Date _____
 Printed _____ Title _____
 Address _____ Phone _____