CAMP RINCE NUA
HISTORY/PHYSICAL

Camper Name: ________________________Date of Birth: ____

Examined By: ____Date: ________________________

PLEASE ATTACH A COPY OF IMMUNIZATION RECORD TO THIS FORM

Height:	Allergies:		Dietary Requirements:
Weight:	1.Drugs		
BP:	3. Food		
	4. Other		

Pertaining to above MEDICAL HISTORY, please clarify and identify special needs while attending camp (use separate sheet if necessary)

Does Camper have any significant or recent fracture, sprain or orthopedic condition?

Does camper require the use of any orthopedic device, brace or bandage? If yes, please clarify (be sure to bring devices with you to camp)

Is camper able to participate in dance program and other active sports and camp activities? Yes No

If no explain:

Medical History (check all that apply)

ADD/ADHD	EATING DISORDER	HAYFEVER	SHIN SPLINTS
ANAPHYLASIS	EMOTIONAL DISORDER/ANXIETY	HEADACHES	SPRAINS
ASTHMA-EIA	ENURESIS	MIGRANES	THYROID DISORDER
CARDIAC DISEASE	FAINTING	SCOLIOSIS	VISUAL DISORDER
DIABETES	FRACTURES	SEIZURE DISORDER	OTHER

ALL CATEGORIES PERTAINING TO MEDICATIONS MUST BE COMPLETED BY PHYSICIAN/PA

Prescription Medications: if none check here ☐

Complete the following according to camper's current regimen. Use separate sheet if necessary

DRUG NAME	DOSE/ROUTE	INTERVAL	REASON

OTC – Stock Medications:

Unless otherwise indicated by the camper's physician or PA in the comment column below, PRN medications and Topical Medications may be administered at the discretion of the Camp Health Director according to complaint, age and weight.

ACETAMINOPHEN: Tabs	Comment
Chewable tabs	
Elixir	
IBUPROFEN: Tabs	
Chewable tabs	
Suspension	
CALCIUM CARBONATE (regular strength):	
PRN Medications	*Comment*
Topical Medications	*Comment*
ANALGESIC HEAT RUB	
ANTIBIOTIC CREAM	
ANTI-ITCH CREAM	
CALAMINE LOTION	
CORTISONE CREAM	
EYE WASH	
INSECT REPELLENT	
SUNSCREEN	

MEDICAL STATEMENT & RELEASE

The above-named Camper has been examined and based on my findings, as indicated on the Health Form and my knowledge of the applicant, I find that he/she *is able to participate in an active camp program*. I have reviewed and completed the medication portion of this form (Prescription, PRN's and Topical)

Physician's Signature ____ Date __________________

Stamp