Camper Health History & Physical Exam Form

Please fill in all requested information below, and include a copy of your child's most recent Physical, completed *after* June 30th, 2023. Incomplete forms will not be accepted and returned if necessary. Remit forms via email to campbreakaway@pyramidlife.org, **no later than June 15, 2024.**

Camper Name: _____ **Date of Birth:** _____

Physical Examination: *To be filled out by a licensed healthcare provider. New York State law requires a signed/dated physical exam within the last 12 months and dates of most current boosters.*

Immunization History: Must be completed with dates. Please record the date (month and year) of basic immunizations and most recent booster doses.

_____ DPT or DP _____ Tuberculosis _____ Other Tetanus _____Hepatitis Vaccination

_____ MMR _____ Polio Vaccine _____ Flu Vaccine _____ Chicken Pox Vaccine

General Condition Or Appraisal

Height:	**Weight:**	**Skin**: _____ Scabies _____ Athlete's Foot _____ Impetigo _____ Infection _____ Pediculosis
Blood Pressure:	**Heart:**	
Nose, throat, ears:	**Posture & Spine:**	
Feet:	**Lungs:**	
Heart:	**Teeth:**	
Urine:	**Menstruation:**	**Abdomen:**
Eyes: Discharge _____ Glasses _____	**Allergies:** Food _____ Drug _____ Other _____	**Nutrition/Dietary Restrictions:**
Current conditions and/or any (pre-existing medical, physical or psychological conditions):		

Current Medications:

Drug	Route	Dosage	Schedule/Information	Comments

Camper Health History & Physical Exam Form

Standard over the counter/PRN medications: (The following are available from Staff Nurse(s) and will be administered at the discretion of an RN, ***unless otherwise indicated below by participant's health care provider TO NOT DISPENSE). Provider should indicate by initializing for each below.***

Drug Name	Route	Dosage	Schedule/Information	Healthcare Provider Initials	Comments
Sunburn Spray/Lotion/Aloe-Gel	Topical	To affected site	2-3 times daily (pm)		
Acetaminophen (Tylenol)	PO (chewable tabs, elixir, tabs)	Per label instructions by age/weight	Q 4 hr prn for pain or fever > _____ F		
Ibuprofen (Motrin)	PO (chewable tabs, elixir, tabs)	Per label instructions by age/weight	Q 6 hr prn for pain or fever > _____ F		
Diphenhydramine Hydrochloride (Benadryl)	PO (chewable tabs, elixir, tabs)	Per label instructions by age/weight	Q 6 hr prn for allergic reaction (hives, insect bite)		
Hydrocortisone Cream	Topical	Per label instructions by age/weight	prn		
Bismuth Subsalicylate (Pepto-Bismol)	PO (liquid or chewable tablets)	Per label instructions by age/weight	Q 30 min to 1 hr prn for diarrhea (no>8doses/24hr)		
Loperamide HCl (Imodium)	Tab or liquid	Per label instructions by age/weight (max of 8mg/24hr)	Per episode/max of 8mg/24hr		
Tums	Chewable Tab	Per label instructions by age/weight	No>10tabs/24hr		
Throat Lozenges	Tab	1 lozenge	No>2/24hr		
Epi Pin	Injectable	.3mg/child<10yrs Adult Size>10yrs	As needed for anaphylaxis		

I believe this child is able to attend camp and participate in all camp activities with the following restrictions and recommendations (attach specific instructions or medications, treatments, and diet):

Health Care Provider's Name (Print): _____ License #: _____

Health Care Provider's Signature: _____ Date: _____

Address: _____ Phone: _____

_____

Camper Health History/Physical Exam Form

Please fill in all requested information below. Incomplete forms will not be accepted and returned if necessary. Please return forms to Camp Breakaway by June 15th, 2024. Copies of completed forms can be sent via email to campbreakaway@pyramidlife.org.

Physical Examination - To be filled out by a licensed healthcare provider *New York State law requires a signed/dated physical exam, within the last 12 months and dates of most current boosters*

Immunization History - Must be completed with dates. Please record the date (month and year) of basic immunizations and most recent booster doses:

___ DPT or DT ___ Tuberculosis ___ Other tetanus ___ Hepatitis vaccination ___ Chicken Pox Vaccine
___ MMR ___ Polio vaccine (most recent) ___ Pneumonia vaccination ___ Recent exposure to contagious disease ___ Flu vaccine

General Condition or Appraisal

Birthdate _____ Ears_____ Menstruation:_____ Skin: scabies_____
Height _____ Nutrition_____ Urine:_____ athlete's foot_____
Weight_____ _____ Allergy:_____ impetigo
Posture & Spine_____ Nose:_____ foods_____ infection_____
Feet_____ Throat-tonsils_____ drugs_____ pediculosis_____
Teeth _____ Lungs:_____ other_____ Current conditions (diabetic, epilepsy, etc.)_____
Blood pressure_____ Eyes:_____ Abdomen_____ _____
Heart_____ discharge:_____ genitals_____ _____
murmur_____ glasses_____ hernia _____ _____

Standard Over the counter/PRN medications: (The following are available from staff Nurse(s) and will be administered at the discretion of an RN, ***Unless otherwise indicated below by participant's health care provider TO NOT DISPENSE) Provider should indicate by initialing for each, below***

Drug Name	Route (indicate formulation[s])	Dosage	Schedule & Indications	Healthcare Provider Initials	Comments
Sunburn Spray/Lotion/Aloe-Gel	Topical	To affected site	2-3 times daily (prn)		
Acetaminophen (Tylenol)	PO (chewable tabs,elixir, tabs)	Per label instr. by age/weight	Q 4 hr prn for pain or fever >_____°F		
Ibuprofen (Motrin)	PO (chewable tabs,elixir, tabs)	Per label instr. by age/weight	Q 6 hr prn for pain or fever >_____°F		
Diphenhydramine Hydrocholoride (Benedryl)	PO (chewable tabs,elixir, tabs)	Per label instr. by age/weight	Q 6 hr prn for allergic reaction (hives, insect bite)		
Hydrocortisone Cream	Topical	Per label instr. by age/weight	prn		
Bismuth Subsellicylate (Pepto-Bismol)	PO (Liquid or chewable tabs)	Per label instr. by age/weight	Q 30 min to 1 hr prn for diarrhea (no>8 doses/24 hr)		
Loperamide HCl (Immodium)	Tab or liquid	Per label instr. by age/weight (max of 8 mg/24 hr)	Per episode/ max 8 mg/24 hr		
Tums	Chewable tab	Per label instr. by age/weight	No>10 tabs/24 hrs		
Throat Lozenges	Tab	1 Lozenge	No>6/24 hr		
Epi Pen	Injectable	.3mg/child<10 yrs Adult size> 10 yrs	As needed for anephylaxis		

Prescription Medications (please complete with patient's current regimen for both scheduled and prn medications)

Drug	Route	Dosage	Schedule & Information	Comments

Additional Orders (as deemed necessary by healthcare provider to be implemented by an RN (i.e. peak flows, dressing changes, cast care, etc.)

I believe this child is able to attend camp and participate in all camp activities with the following restrictions and recommendations (attach specific instructions or medications, treatments and diet):

Health Care Provider's Name (print)_____ License #:_____
Health Care Providers Signature:_____ Date:_____
Address:_____ Phone:_____