**SILVER CAMP**

**CAMPER PHYSICAL FORM**

This form must be completed and **signed by a physician.**

Physical Examination Date (must be completed in the last year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❐ The camper listed above is physical and mentally well to participate in ALL activities at camp.

❐ The camper listed above has the following limitations or restrictions on camp activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Dietary Needs or Restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical or Psychological Conditions/Illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Camper at risk for any Vaccine Preventable Diseases (Please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Female: Has menstruation started? \_\_\_\_\_\_\_\_\_\_\_ If not, has she been told about it? \_\_\_\_\_\_\_\_\_\_\_\_

 Special considerations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Over the Counter Medications Approved by Physician**

*Please****CHECK the following medications*** *that the camper listed above may be given**by Silver Camp medical staff. Leave un-checked medications that we should NOT give your child.****\*\*\*MD MUST to fill out dosages for diphenhydramine (Benadryl) and Cetirizine (Zyrtec) for camper to receive medication at camp.***

|  |  |  |
| --- | --- | --- |
| **Medication** | **Indications** | **Dose/Route/Frequency** |
| ❐Calamine Lotion | Itchy suspected bug bites, poison ivy or other skin irritants. | Apply to intact itchy skin, q4 hrs PRN |
| ❐Diphenhydramine Spray | Itchy suspected bug bites, poison ivy or other skin irritants. | Apply to intact itchy skin, q4 hrs PRN |
| ❐Hydrocortisone Cream 1% | Itchy suspected bug bites, poison ivy or other skin irritants. | Apply to intact itchy skin, q4 hrs PRN |
| ❐Aloe-Vera | Pain due to mild sunburn. | Apply to intact affected skin, q4 hrs PRN |
| ❐Diphenhydramine [Benadryl] (liquid) 12.5mg/5mL | Pediatrics 6-11 yrs old. Allergic reaction (i.e., hives, itching, wheezing, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | **TO BE FILLED OUT BY MD:**  |
| ❐Diphenhydramine [Benadryl] (tablet) 25mg | Pediatrics 12-17 yrs old. Allergic reaction (i.e., hives, itching, wheezing, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | **TO BE FILLED OUT BY MD:** |
| ❐Cetirizine [Zyrtec] (liquid) 1mg/1mL:  | Pediatrics 2-17 yrs old. Allergic reaction (i.e., hives, itching, wheezing, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | **TO BE FILLED OUT BY MD:** |

**Prescription Medications**

All prescription medications must be turned over to camp staff in the first aid room except for emergency medications such as epinephrine auto-injectors and inhalers.

My child will be providing the following prescription or non-prescription medications at camp:

|  |  |  |
| --- | --- | --- |
| **Medication** | **Indications** | **Dose/Route/Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**\*\*\*Please include prescription care plans (FARE) or action plans when available\*\*\***

**New York Department of Health requires all medications to have the following documentation**:

* Complete name of patient
* Date prescription filled
* Expiration date
* Directions for use/precautions (if any), and storage (if any)
* Dispensing pharmacy name and address
* Name of physician prescribing medication

**Please choose from the following options**:

❐ My camper will be self-carrying their emergency medications and will have full responsibility for keeping it with them. Silver Bay YMCA is not responsible if medications are lost.

❐ Medication will be carried by the counselor and will be checked in/out each day.

❐ Medication will be stored/locked in the temperature controlled First Aid Room located in the Children’s Pavilion.

\*All medications must be checked in and out every day with First Aid staff if not keeping it at the First Aid room Monday through Friday.