Outdoor School Health History/Physical Exam Form

Student Name_____ School:_____

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 medications are available in the infirmary and will be administered at the discretion of an RN, if approval is indicated by the camper's healthcare provider)

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 >_____^{0}F		
Ibuprofen (Motrin)	PO (chewable tabs,elixir, tabs)	Per label instr. by age/weight	Q 6 hr prn for pain or fever >_____^{0}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 Subsalicylate (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 anaphylaxis		

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:_____

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Please Print (This side and top of back page to be filled in by **PARENT** before physical examination).

Camper Name_____ Birth date:_____ Age _____ Sex _____ Home Phone_____

Parent/Guardian _____ Home Address_____

Business Address_____ Business/Cell Phone_____

Other Parent/Guardian_____ Home Address:_____ Home Phone_____

Business Address_____ Business/Cell Phone _____

In the event of emergency, and parent or guardian cannot be reached, notify _____ Relationship to camper_____

Address_____ Home Phone_____ Business/Cell Phone_____

Note:

This person must be a relative over 18. If someone is not a relative, a "notarized statement" authorizing that person to approve medical treatment is necessary. In the event of an injury or illness that does not require removal to a hospital, parents shall not be notified unless medical personnel's concerns dictate. When injuries or illnesses require a trip to the hospital, either the RN accompanying the camper or the camp director will notify the parents.

Health History - To be completed by **PARENT/GUARDIAN** *(give approximate date of illness or 'no" if not applicable)*

___ Frequent ear infections ___ hypertension ___ bleeding/clotting

___ heart defect/disease ___ psychiatric treatment ___ bed wetting

___ convulsions ___ mononucleosis ___ fainting

___ diabetes ___ sleep walking ___ asthma

Allergies

___hay fever

___ other

___ plants

___ insect stings

___ food:_____

_____

Diseases

__ chicken pox

__ measles

__ German measles

__ mumps

Medication Allergies:_____

Current medication (send in original container with instructions):_____

Operations or serious injuries (dates):_____ Disability of chronic or recurring illness:_____

Dietary modifications:_____ Any specific activities limited:_____

Name of dentist/orthodontist:_____ Phone:_____

Name of family physician:_____ Phone:_____

Medical Insurance

Soc. Sec. No.	Policy Holder's Name	Name of insurance carrier and type of coverage	Policy No.	Group No.

Authorization for release for information to above named insurance carrier

Signature_____ Date_____ Relationship to camper (parent, etc.)_____

Address of Insurance Company

Your personal medical policy is your child's primary coverage. All campers must have medical insurance to attend camp. All registered campers are covered by excess coverage accident insurance while at camp.

Important - This Box Must Be Completed For Attendance

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted. Authorization for treatment: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine test, treatment and necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp Director to secure and administer treatment, including hospitalization, for my child, as named above. The completed forms may be photocopied for trips out of camp.

Meningococcal Meningitis Vaccination Response

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response for every camper who attends camp for seven (7) or more nights. Please check one box and sign below.

____ My child has had the meningococcal meningitis immunization (Menomune™) within the past 10 years. Date received:_____
Note: The vaccine's protection lasts for approximately 3 to 5 years. Re-vaccination may be considered within 3-5 years)

____ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will **not** obtain immunization against meningococcal meningitis disease.

Signature of parent or guardian_____

I also understand and agree to abide with the restrictions placed on my camp activities. Signature of minor:_____

Licensed physician to fill out back of this form