QUINIPET SUMMER 2018 CAMPER HEALTH FORM

THIS FORM MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER & BE ACCOMPANIED BY CAMPER'S IMMUNIZATION RECORDS. DUE JUNE 1, 2018

Camper Name_____ Age/Date of Birth_____

Height_____ Weight_____ Blood Pressure_____ Date of Last Physical Exam_____

The following non-prescription medications are stocked in the Camp Health Center and used on an as-needed basis to manage illness & injury.
MEDICAL PERSONNEL: PLEASE CIRCLE WHICH MEDICATIONS MAY BE ADMINISTERED TO THIS CAMPER AS DIRECTED FOR AGE:

FOR FEVER/PAIN			FOR COLD/ALLERGIES			FOR STOMACH			FOR TOPICAL TREATMENT		
Acetaminophen	Y	N	Tylenol Cold	Y	N	Calcium antacid (Tums)	Y	N	Antibiotic Ointment	Y	N
Ibuprofen	Y	N	Diphenhydramine (Benadryl)	Y	N	Loperamide (Immodium)	Y	N	Caladryl (or Equivalent)	Y	N
			Pseudoephedrine (Sudafed)	Y	N	Docusate Sodium (Stool Softener)	Y	N	Tecnu (Poison Ivy Wash)	Y	N
			Loratadine (Claritin)	Y	N	Pepto Bismol	Y	N	Burn Ointment	Y	N
			Fexofenadine (Allegra)	Y	N				Aloe	Y	N
			Guaifensein (Mucinex)	Y	N				Calamine lotion	Y	N
			Cetirizine (Zyrtec)	Y	N				Hydrocortisone cream	Y	N
			Robitussin DM	Y	N	**FOR MOTION SICKNESS**			Anti-sting/Itch spray	Y	N
			Cepocol Lozenges/ Spray	Y	N	Bonine (Meclizine)	Y	N	White Vinegar Topical	Y	N
			Cough Drops	Y	N	Dramamine	Y	N	Saline Wound Wash	Y	N
									Chloraseptic spray	Y	N

THIS CAMPER WILL TAKE THE FOLLOWING MEDICATION(S) WHILE AT CAMP:
(Please include EPI Pens & Rescue Inhalers, if applicable.)
All medications must come to Camp in their original packaging, prescribed for the camper.

NAME OF MEDICATION	DOSAGE	SCHEDULE	SPECIFIC INSTRUCTIONS

ALLERGIES Please explain specific allergen and reaction: _____

_____

_____

Is this camper being treated for any medical condition(s) at this time?___YES ___ NO If YES, please descibe condition & treatment:

_____

_____

Do you feel this camper will require limitation or restriction on activities while at camp? ___YES ___ NO If YES, please describe:

_____

_____

I have reviewed this Camper Health Form and verify the information contained herein. It is my opinion that this camper is physically and emotionally fit to participate in an active camp program.

PHYSICIAN'S STAMP HERE

Health Provider Signature_____ **Date**_____

Parent/Guardian Signature_____ **Date**_____

Parent/Guardian Name (please print)_____