HAWTHORNE VALLEY FARM SUMMER CAMP PROGRAMS

327 Route 21C, Ghent, NY 12075 (518) 672-4465 X201 FAX (518) 672-7608

**PHYSICAL EXAM FORM – COMPLETED BY LICENSED MEDICAL PERSONNEL**

**Camper Name**:_____ DATES OF CAMP _____

□ Male □ Female DOB:_____/_____/_____ ☐ HOUSE CAMP ☐ FIELD CAMP

**Custodial parent(s)/guardian(s)** _____
Home phone: ( ) cell: ( ) Email: _____

**Primary Physician** _____
Telephone: ( ) Email: _____

Exam Date:_____ Weight:_____lbs. Height:_____ Blood Pressure_____/____

**Allergies and Reactions:**
Medications:_____

Environmental:_____

Foods:_____

**Diet/Nutrition:**
___ eats a regular diet;
___ Special dietary needs/restrictions:_____

**Health History - Please circle all current and past health issues**

| | | | | |
|---|---|---|---|---|
| Respiratory (ex: asthma) | Cardiac (ex: murmur) | Headaches | Diabetes | Nose bleeds |
| Homesickness | Sleep-walking | Bed-wetting | Surgery | Ear infections/ tubes |
| Seizure disorder | Eating disorder | Psychiatric | Behavioral | ADD/ADHD |
| Head Injury/ Concussion | Glasses/ contacts | Dental (ex: braces) | Skin problems | Mononucleosis in the past 12 months |
| Crutches/ casts | Difficulty during menses | | | Other |

**Physical restrictions:**_____

Camper Name: _____DOB: ____/____/_____

Physician: Please indicate approval for administration by circling yes or no. This will serve as a standing physicians order for six months from the date on the signature line.

| **Medication** | **Route** | **Dosage** | **Schedule & Indications** | **Permission** |
|---|---|---|---|---|
| Tylenol (acetaminophen) | By mouth (elixir or tablet) | Per label instructions by age and weight | Every 4 hours prn pain or fever > ___F | Yes/ No |
| Motrin (ibuprofen) | By mouth (elixir, suspension or tablets) | Per label instructions by age and weight | Every 4 hours prn pain or fever > ___F | Yes/ No |
| (Benadryl) diphenhydramine HCl | By mouth (elixir, tablets, or capsules). Apply topically | Per label instructions by age and weight | Every 6 hours prn allergies, or insect bites | Yes/ No |
| Robitussin (guaifenesin) | By mouth (syrup) | Per label instructions | Every 4 hours prn cough | Yes/ No |
| Claritin (loratidine) | By mouth (tablets) | 10 mg | Daily prn allergy symptoms | Yes/ No |
| Zyrtec (Cetirizine HCl) | By mouth (tablets) | 10 mg | Daily prn allergy symptoms | Yes/ No |
| Allegra (fexofenadine) | By mouth (tablets) | 180 mg | Daily prn allergy symptoms | Yes/ No |
| Tums (calcium carbonate) | By mouth (chewable tablets) | 840 mg | Every 2 hours prn acid indigestion | Yes/ No |
| Lactaid (lactase) | By mouth (caplets) | Three caplets | With first bite of dairy | Yes/ No |
| Sunblock or sunscreen | Apply topically | SPF>30 | Apply prn prior to sun exposure | Yes/ No |
| Insect repellant | Apply topically | Aerosol or pump | Per label instructions | Yes/ No |
| Bacitracin Ointment | Apply topically | Bacitracin Zinc 500 U | Apply 1-3x/day daily prn minor cuts | Yes/ No |
| Hydrocortisone cream | Apply topically | Hydrocortisone 1% | Apply 3-4x/day prn skin irritation | Yes/ No |
| Antifungal cream | Apply topically | Tolfnaftate1% | Apply twice daily to soothe itching | Yes/ No |
| Calamine Lotion | Apply topically | Per label instructions | Apply prn itching | Yes/ No |
| Mouth Rinse/ Analgesic | By mouth (rinse) | Per label instructions | PRN for pain associated with braces | Yes/ No |
| Cough drops | By mouth (drops) | Per label instructions | Prn sore throat | Yes/ No |
| Arnica Nettle gel | Apply topically | Per label instructions | Apply prn 1st and 2nd degree burns, sunburn, insect bites | Yes/ No |
| Arnica ointment | Apply topically | Per label instructions | Apply prn sprains, bruises, joint swelling | Yes/ No |
| Calendula ointment | Apply topically | Per label instructions | Apply prn to superficial inflammation of the skin | Yes/ No |
| Mercurialis Calendula ointment | Apply topically | Per label instructions | Apply prn minor open wounds | Yes/ No |
| Traumeel | Apply topically | Per label instructions | Apply prn sprains, bruises, joint pain | Yes/ No |
| Rescue Remedy | By mouth (tincture) | Per label instructions | As needed with minor injury | Yes/ No |

Camper Name: _____DOB: ____/____/___ Dates of Camp:_____

**Medications**: Please list all current prescribed, as needed, & over the counter medications, supplements, vitamins or topical ointments currently used by the above noted minor. **Absolutely no prescription or over the counter medications, supplements, vitamins or topical ointments can be administered without a physician order in accordance with NYS law**.

| Medication | Dosage | Route | Schedule | *Self-Carry |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

* Campers 8 years or older may self-carry only the following medications with written permission from their physician: Epi-pen, rescue inhalers, & insulin pumps.

**IMMUNIZATION**

**Please provide a copy of immunization records or fill out History below**, Or parents need to provide a letter stating religious exemption from immunizations, fax to (518) 672-7608

| Immunization | Dose 1 date | Dose 2 date | Dose 3 date | Dose 4 date | Dose 5 date |
|---|---|---|---|---|---|
| DTP/aP | | | | | |
| Hep B | | | | XXXXXXXX | XXXXXXXX |
| Hib | | | | | XXXXXXXX |
| MMR | | | XXXXXXXX | XXXXXXXX | XXXXXXXX |
| Pneumococcal | | | | | XXXXXXXX |
| Polio | | | | | XXXXXXXX |
| Varicella (or proof of disease) | | | XXXXXXXX | XXXXXXXX | XXXXXXXX |
| Meningococcal | | XXXXXXXX | XXXXXXXX | XXXXXXXX | XXXXXXXX |

**It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).**

_____

Physician/Healthcare Provider (PRINT)

_____ _____

Physician/Healthcare Provider signature Date

Healthcare Provider Address:_____

Telephone: ( ) -

Fax or email form to: (518) 672-7608 or Helen@hawthornevalleyfarm.org