HAWTHORNE VALLEY FARM SUMMER CAMP PROGRAMS

327 Route 21C, Ghent, NY 12075 (518) 672-4465 x 201 farmcamp@hawthornevalley.org

PHYSICAL EXAM FORM – TO BE COMPLETED BY LICENSED MEDICAL PERSONNEL

Camper Legal Name:_____ DATES OF CAMP _____

Camper Preferred Name (if different from legal name): _____

DOB:_____/_____/_____ ☐ HOUSE CAMP ☐ FIELD CAMP

Gender: □ Male □ Female □ Transgender Female □ Transgender Male □ Non-Binary

Preferred Pronouns: □ He/him/his □ She/her/hers □ They/them/theirs □ Other _____

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 issues	Mononucleosis in the past 12 months
Crutches/ casts	Difficulty during menses			Other

Camper Name: _____DOB: ____/____/_____

Please note any physical restriction here: _____

_____

Medications:

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

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

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.

Immunizations:
Please provide a copy of immunization records or fill out history below. Alternatively, parents need to provide a letter stating religious exemption from immunizations.

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 farmcamp@hawthornevalley.org