

Camp Eagle Hill Medical Form – PART B (PHYSICIAN FORM)

MEDICAL EXAMINATION (to be filled in by physician)

CAMPER'S NAME _____

Height _____ Weight _____ BP _____ Hgb. _____ Urinalysis _____

1. This child is under the care of a physician for the following conditions:

2. Please state any physical disability that this child has: _____
3. Has this child had any surgery? If yes, for what, and when? _____
4. Has this child ever had any serious illnesses? If yes, what type, and when?

5. Has this child had any recurring illnesses? _____
6. Are there to be any restrictions for this child while in camp? _____
7. Are swimming and diving permitted? _____
8. Is strenuous activity permitted? _____
9. Any additional health information or special instructions for this child? _____
10. Any treatment to be continued at camp? _____
11. Any medically prescribed meal plan or dietary concerns? _____
12. Any special instructions for the camp? _____

I have examined _____ and have reviewed his/her health history. This health history is correct so far as I know. It is my opinion that he/she is physically able to engage in all activities, except as noted above.

Date of Form Completion _____ M.D.
Examining Physician's Signature _____

MEDICATIONS TO BE TAKEN AT CAMP (to be filled in by physician)

Please list all medications, including all over-the-counter or non-prescription drugs, taken routinely or as needed (PRN). Please send along enough medication for your child's session of camp. In addition, please keep any medication in original packaging so that the original bottle can identify the prescribing physician. (in the case of prescription medication) This will allow us to see the name of the medication, the dosage to be taken, and the frequency of administration.

MEDICATION #1: _____ **Dosage** _____ **Specific Times Taken Each Day** _____

Reason For Taking _____

MEDICATION #2: _____ **Dosage** _____ **Specific Times Taken Each Day** _____

Reason For Taking _____

MEDICATION #3: _____ **Dosage** _____ **Specific Times Taken Each Day** _____

Reason For Taking _____

OVER

EMERGENCY MEDICAL INFORMATION and HEALTH HISTORY

(To Be Filled in by Parent with help from Child's Physician)

EMERGENCY MEDICAL INFORMATION

1. Will camper have an epinephrine pen at camp? (circle one) YES NO

If so, for what condition? _____

2. Is camper allergic to any foods, medications, plants, animals, or insects? (circle one) YES NO

If so, what is camper allergic to? _____

3. Is camper asthmatic or does camper have any condition that requires any special care, medication, or diet? (circle one) YES NO

If so, what condition and what kind of care is needed? _____

GENERAL MEDICAL QUESTIONS

<u>Has/does the camper:</u>	YES	NO		YES	NO
1. Had any recent injury or infectious disease?	___	___	21. Wear braces or have any special caps/crowns on teeth?	___	___
2. Have a chronic or recurring illness/condition?	___	___	22. Have an orthodontic appliance being brought to camp?	___	___
3. Ever been hospitalized?	___	___	23. Have any skin problems? (e.g.- itching, rash, acne)	___	___
4. Ever had surgery?	___	___			
5. Have frequent headaches?	___	___	24. Have diabetes?	___	___
6. Ever had a head injury?	___	___	25. Had problems with diarrhea or constipation?	___	___
			26. Had mononucleosis in the past 12 months?	___	___
7. Ever been knocked unconscious?	___	___	27. Have done any sleepwalking?	___	___
8. Wear glasses, contacts, or protective eyewear?	___	___	28. Have a history of bedwetting?	___	___
9. Ever had frequent ear infections?	___	___	29. Ever had an eating disorder?	___	___
10. Ever passed out during or after exercise?	___	___	30. Ever had any emotional difficulties for which professional help was sought?	___	___
11. Ever been dizzy during or after exercise?	___	___	31. For female campers, has menstruation begun?	___	___
12. Ever had seizures?	___	___	32. Any special considerations concerning menstruation?	___	___
13. Ever had chest pain during or after exercise?	___	___			
14. Ever had high blood pressure?	___	___			
15. Ever been diagnosed with a heart murmur?	___	___			
16. Ever had heart defects/disease?	___	___			
17. Ever had bleeding/clotting problems?	___	___			
18. Ever had rheumatic fever?	___	___			
19. Ever had back problems?	___	___			
20. Ever had problems with knees or joints?	___	___			

Please explain any "yes" answers. Note the question number.

FOR MEDICAL NOTIFICATION POLICY (see our Parents' Guide)- please note here any special medical communications you would like to receive from us this summer:

Physician's Name (printed) _____

Dentist's Name (printed) _____

Physician' Phone Number () _____

Dentist's Phone Number () _____