

CAMP PA-QUA-TUCK

2010 Physician's Report

Date of this Report _____

Camper's Name _____

DOB: _____ MALE _____ FEMALE _____

Diagnosis (Primary) _____

Diagnosis (Secondary) _____

Description of Camper's **General Health:** _____

Allergies ... Y or N _____

Dietary Restrictions ... Y or N _____

Does child have a **Shunt?** Y or N _____

Location _____

Signs of malfunction _____

Does child have **Seizures?** Y or N _____

Severity _____

Frequency _____

Does this child need side rails on the bed? Y or N _____

Is child on **Medication?** Y or N _____

| Medications | | | |
|-----------------|----------|------|------|
| Medication Name | Strength | Dose | Time |
| | | | |
| | | | |
| | | | |
| | | | |

Physical Exam:

Vital Signs:

Height _____ Weight _____

Resp Rate (resting) _____ Blood Pressure (resting sitting) _____

Eyes _____ Throat _____ Ears/Hearing _____ Nose _____

_____ Neck/Thyroid _____ Heart _____

Abdomen/Hernia _____ Spine _____ Extremities _____

Head _____ Eyes/Vision _____ Mouth/Teeth _____

Lungs _____ Skin _____

Noteworthy physical findings _____

Immunizations ... An up-to-date immunization status is required to attend camp. Please list the most recent immunizations given to this camper: (copy of doctors current immunization record **preferred**)

DPT series (campers under age 10) _____ Mumps _____

Td (Tetanus... campers over age 14) _____ German Measles(Rubella) _____

PROHIB "B" (Campers under age 6) _____ TOPV or OPV or Salk (Polio) _____

Last Tuberculin (TB) skin test was _____ Measles (Rubeola) _____

Haemophilus influenza type b _____ hepatitis b _____

Varicella (chicken pox) _____

The results of the last TB skin test was: **POSITIVE** **NEGATIVE** (circle one)

Physicians Authorization:

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to attend Camp Pa-Qua-Tuck, a residential camp for handicapped children and engage in activities except those noted below:

| | |
|--|---|
| I also approve of the below circled OVER-THE-COUNTER medications to treat minor illnesses and injuries. Should symptoms persist, the physician's office will be notified. (generic brands may be substituted for name brands) | |
| COUGH: Robitussin Y or N | STUFFY NOSE: Sudafed..... Y or N |
| ANTI-HISTAMINE: Benedryl..... Y or N | FEVER, PAIN, HEADACHE Tylenol Y or N Chewable Tablets..... Y or N |
| DIARRHEA: Imodium..... Y or N | CONSTIPATION: Prune Juice..... Y or N Power Pudding..... Y or N Ducalux Tablets..... Y or N Ducalux Suppository..... Y or N Fleets Enema..... Y or N |
| CUTS, SCRAPES: Bacitracin..... Y or N | MENSTRUAL CRAMPS: Ibuprofen..... Y or N Tylenol..... Y or N |
| UPSET STOMACH: Pepto Bismal..... Y or N | SUN PROTECTION, SUN BURN: Sun Block..... Y or N Solarcaine..... Y or N |

Print Physician's Name

Physician's Address

Physician's Signature

City State Zip

Date

(Area Code) Telephone Number

Parent's approval for OVER-THE-COUNTER Medications: _____
Parent's Signature

Without the physician and parent's approvals, we cannot give OVER-THE-COUNTER medications at camp.