MEDICAL EVALUATION FORM PAGE 1

***Instructions:* Pages 1 and 2 must be fully completed by the Physician and submitted with Camper Application.**

Camper Name_____Date of Birth_____ has had a complete history and physical exam on_____
Month/Day/Year Month/Day/Year

Immunization Records MUST BE ATTACHED! ☐ **Check here if immunization records are attached.**

Screening / Test Results

Height:	**BMI:**	**Vision/Type of Screening**
Weight:	□ Normal	With Glasses R 20 / L 20 /
Blood Pressure:	□ Abnormal	Without Glasses R 20 / L 20 /
Pulse:	Min:	Does child wear contact lenses? Y N
HCT/Hgb:	Slight:	**Auditory /Type of Screening**
Urinalysis:	Mod:	Right Pass / Fail
Gross Dental:	Marked:	Left Pass / Fail
Lead (Date/Result):	□ Referral to:	
TB: In high-risk group? □ yes □ no		
TB & other Test Results: (Sickle Cell, etc.)		
Test	**Date**	**Result**

Disease Assessment

Yes No		**Details**	**Date of Onset**
□	□ Asthma	□ Mild □ Moderate □ Severe □ Exercise Induced □ unclassified	
□	□ Lung/Respiratory Illness		
□	□ Diabetes	□ Type I □ Type II	
□	□ Seizure Disorder	Type:	
□	□ Measles/Mumps	If yes, when?	
□	□ Heart Conditions	Type:	
□	□ Obesity		
□	□ Kidney/Liver Diseases	Type:	
□	□ Immune Deficiencies or other conditions causing immunocompromised state	Type:	
□	□ COVID-19	If yes, date of positive test:	
□	□ Other: Please Specify		

Allergies

Please list all allergies including type of reaction.

List of Allergies	**Type of reaction**	**Risk of Anaphylaxis?**
		□ YES □ NO
		□ YES □ NO
		□ YES □ NO

Additional Orders: As deemed necessary by health care provider to be implemented by an R.N. (i.e. peak flows, blood draws/lab work, dressing changes, cast care, feeds via GT, etc.):

_____

_____

Limitations on Activities:

Swimming_____Diving_____Hiking_____Athletics_____Other:_____

Explain above:_____

MEDICAL EVALUATION CONTINUED

(to be completed by the Physician)

Camper Medication

Please include patient's current regimen for **both prescription and PRN medications,** use additional paper if needed.

PLEASE FILL IN EACH COLUMN:

DRUG NAME & STRENGTH	ROUTE	DOSAGE	FREQUENCY	TIME OF DAY	WITH FOOD?	COMMENTS
				□ AM □ PM □ bedtime	□ yes □ no	
				□ AM □ PM □ bedtime	□ yes □ no	
				□ AM □ PM □ bedtime	□ yes □ no	
				□ AM □ PM □ bedtime	□ yes □ no	
				□ AM □ PM □ bedtime	□ yes □ no	
Include Inhaler here if applicable:				□ AM □ PM □ bedtime	NA	**Permission to carry? □ yes □ no**
Include Epi Pen here if applicable:				□ AM □ PM □ bedtime	NA	**Permission to carry? □ yes □ no**

Stock Over-the-Counter/PRN Medication

The following Standard "Over the Counter / PRN Medications" are available in the Health Center to be administered if needed, per the family physician's instructions/permission.

EACH LINE IN THIS SECTION MUST HAVE YES OR NO CIRCLED.

Drug Name (Generic equivalents may be used)	**Dosage**	**Route**	**Indications**	**Healthcare Provider Permission**	**Comments**
Diphenhydramine	As per pkg by wt. & age	PO	Allergic Reactions	Yes / No	
Burn Gel	Apply to minor burns	Topically	Minor Burns	Yes / No	
Laxative	As per pkg by wt. & age	PO	No BM x 3 Days	Yes / No	
Acetaminophen	As per pkg by wt. & age	PO	Temp. ≥ 100°F or Pain	Yes / No	
Ibuprofen	As per pkg by wt. & age	PO	Temp. ≥ 100°F or Pain	Yes / No	
Hydrocortisone	Apply to effected area 3x/day	Topically	Itch	Yes / No	
Cough Drops	As per pkg by wt. & age	PO	Cough or Sore Throat	Yes / No	
Antacid	As per pkg by wt. & age	PO	Upset Stomach	Yes / No	
Antibiotic Oint.	Apply to effected area 3x/day	Topical	Scrapes or Cuts	Yes / No	
Miconazole	Apply to effected area 3x/day	Topical	Rash/Fungus	Yes / No	
Abx ear drops	As per pkg	Otic	Acute otitis externa	Yes / No	

This form is not exhaustive or restrictive. It is meant by the Putnam County Health Department only as a guide. Please note, if the provider has not circled yes, it means no. Following the above without the provider's explicit direction is practicing medicine without a license.

I certify that I have on this date examined the above named camper and that on the basis of my examination and the medical history as furnished to me, I have found no reason which would make it medically inadvisable for this camper to participate in physically strenuous activities.

Signature of Physician_____ **Date of Examination**_____

Please Print: Physician's Name_____**License#** _____

Address_____ **Phone#**_____