

MEDICAL EVALUATION FORM

Instructions: Pages 1 and 2 must be fully completed by Medical Provider and submitted to Camp Felix via Campdoc.

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:	<input type="checkbox"/> Normal	With Glasses R 20 / L 20 /
Blood Pressure:	<input type="checkbox"/> 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):	<input type="checkbox"/> Referral to:	
TB: In high-risk group? <input type="checkbox"/> yes <input type="checkbox"/> no		
TB/other Test Results: (Sickle cell, etc)		
Test	Date	Result

Disease Assessment

Yes No	Details	Onset Date
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Exercise Induced <input type="checkbox"/> unclassified	
<input type="checkbox"/> <input type="checkbox"/> Lung/Respiratory Illness		
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> Type I <input type="checkbox"/> Type II	
<input type="checkbox"/> <input type="checkbox"/> Seizure Disorder	Type:	
<input type="checkbox"/> <input type="checkbox"/> Measles/Mumps	If yes, when?	
<input type="checkbox"/> <input type="checkbox"/> Heart Conditions	Type:	
<input type="checkbox"/> <input type="checkbox"/> Obesity		
<input type="checkbox"/> <input type="checkbox"/> Kidney/Liver Diseases	Type:	
<input type="checkbox"/> <input type="checkbox"/> Immune Deficiencies or other conditions causing immunocompromised state	Type:	
<input type="checkbox"/> <input type="checkbox"/> Other: Please Specify		

Allergies

Please list all allergies including type of reaction.

List of Allergies	Type of reaction	Risk of Anaphylaxis?
		<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> YES <input type="checkbox"/> NO

Additional Orders: As deemed necessary by health care provider to be implemented by nurse at camp (i.e. peak flows, dressing changes, cast care, etc.):

Limitations on Activities:

Swimming _____ Climbing _____ Hiking _____ Athletics _____ Other: _____

Explain above: _____

CAMPER MEDICATIONS*(to be completed by Medical Provider)***PRESCRIPTION MEDICATIONS:**

All medications that must be taken during camp (July/August) must be listed below.

PLEASE FILL IN EACH COLUMN

DRUG NAME & STRENGTH	ROUTE	DOSAGE	FREQUENCY	TIMES TAKEN	WITH FOOD?	COMMENTS
				<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> as needed
				<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> as needed
				<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> as needed
				<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> as needed
				<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> as needed
				<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> as needed
<i>Include Inhaler here if applicable:</i>				<input type="checkbox"/> as needed	NA	Permission to carry? <input type="checkbox"/> yes <input type="checkbox"/> no
<i>Include Epi Pen here if applicable:</i>				<input type="checkbox"/> as needed	NA	Permission to carry? <input type="checkbox"/> yes <input type="checkbox"/> no

PRN MEDICATIONS:The following standard OTC/PRN medications are available in the Health Center *if needed*, per the medical provider's instructions/permission.**PLEASE CHECK YES OR NO FOR EACH MEDICATION**

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

Important Note: This form is not exhaustive or restrictive. Please note, if the provider has not circled yes, it means no.

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# _____