

# Camp Felix Update to Health Form

Please, submit this form to Camp Felix if there are any changes before the start of camp

Name of Camper: \_\_\_\_\_

Please include below any changes to medication since the Medical forms were submitted. Note changes in dose (strength or number of mgs), the number of times per day that medicine is taken, and make sure doctor signs at the bottom.

## MEDICATION CHANGES:

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

| DRUG NAME & STRENGTH                       | ROUTE | DOSAGE | FREQUENCY | TIME OF DAY                                                                              | WITH FOOD?                                               | COMMENTS                                                                             |
|--------------------------------------------|-------|--------|-----------|------------------------------------------------------------------------------------------|----------------------------------------------------------|--------------------------------------------------------------------------------------|
|                                            |       |        |           | <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> bedtime | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                                                      |
|                                            |       |        |           | <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> bedtime | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                                                      |
|                                            |       |        |           | <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> bedtime | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                                                      |
|                                            |       |        |           | <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> bedtime | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                                                      |
|                                            |       |        |           | <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> bedtime | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                                                      |
|                                            |       |        |           | <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> bedtime | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                                                      |
|                                            |       |        |           | <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> bedtime | <input type="checkbox"/> yes <input type="checkbox"/> no |                                                                                      |
| <i>Include Inhaler here if applicable:</i> |       |        |           | <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> bedtime | NA                                                       | <b>Permission to carry?</b> <input type="checkbox"/> yes <input type="checkbox"/> no |
| <i>Include Epi Pen here if applicable:</i> |       |        |           | <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> bedtime | NA                                                       | <b>Permission to carry?</b> <input type="checkbox"/> yes <input type="checkbox"/> no |

\*\*\***Remember** - campers cannot receive vitamins, supplements, herbal preparations or homeopathic remedies without a prescription.

## MEDICAL HISTORY CHANGES:

Note any changes in the camper's physical or medical condition since the original health form was submitted.

### Medical Change or Condition:

Date of Onset: \_\_\_\_\_ Condition; \_\_\_\_\_

Date of Onset: \_\_\_\_\_ Condition; \_\_\_\_\_

### Physician Signature:

Signature of Physician \_\_\_\_\_ Date of Examination \_\_\_\_\_

Please Print: Physician's Name \_\_\_\_\_ License# \_\_\_\_\_

Address \_\_\_\_\_ Phone# \_\_\_\_\_

### Parent/Guardian Signature:

Parents Signature: \_\_\_\_\_ Date: \_\_\_\_\_