Office Use Only

Name______________________________

Cabin #_____ Outpost Lodge

Counselor/Leader______________________________

Dates of Camp: Sunday, June 25 – Saturday, July 1, 2017

Physician's Report for Camp Season

Lancaster Presbyterian Church Summer Youth Camp

at Duffield Camp and Retreat Center, Inc.

Name of Camper: ______________________________

Date of physical: ____/_____/______ (campers must be within one year of attending camp)

Has camper been hospitalized within the past 3 years? __________

If yes explain details and dates: ______________________________

Patient's HT _____ WT _____ P _____ BP _____RR _____

PHYSICAL EXAMINATION

SYSTEM	WITHIN NORMAL LIMITS	ABNORMAL	REASON
HEAD, NECK			
EARS,NOSE,THROAT			
LUNGS			
HEART			
ABDOMEN			
GENITALIA			
SPINE			
EXTREMITIES			
NEURO			
SKIN			
EYES			

MEDICATIONS

Please list all medications (including over the counter or non prescription drugs) being taken. Bring enough medication to last the entire time at camp. Keep in original packaging/bottle that identifies the medication, the prescribing doctor (if prescription drug), the dosage and frequency of administration.

MEDICATION	DOSAGE	TIMES GIVEN	REASON	SPECIAL INSTRUCTIONS

Signature of Physician______________________________**Date**______________

Print Name or stamp ______________________________

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at Duffield Camp and Retreat Center, Inc.

Name of Camper:____

Date of physical: ____/_____/______ (campers must be within one year of attending camp)

Immunization History: Provide the **month and year for each immunization.** All immunizations must be current. Copies of immunization forms from health-care providers are acceptable; please attach to this form.

Immunization	Dose 1,	Dose 2,	Dose 3,	Dose 4,	Dose 5
DTaP or TdaP					
DT or TdaP					
MMR					
IVP					
HIB					
PCV					
Hepatitis A					
Hepatitis B					
Varicella					
Meningococcal					
Influenza					

Has the child been tested for Tuberculosis (TB)? Yes No

If Yes, test Date: ___/___/______ **circle one: Negative Positive**

If positive please explain.____

Allergy Information: Does not apply (no allergies)

Allergy to:	Reaction:	Treatment:
Dust/Mold		
Insect Bites:		
Animals:		
Latex		
Sunscreen		
Food:		
Food:		
Medications:		
Medication:		

(Must bring current epi pen, bee sting kit, lactose free milk, etc. if needed.)

Signature of Physician_________________________________**Date**______________

Print Name or stamp ____

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OVER THE COUNTER MEDICATION FORM

Your medical doctor must complete this form

I hereby authorize that the following medications may be given to the above named camper at Camp Duffield after nursing assessment.

Bactine (topical) for minor wound care, first aid as needed

Triple Antibiotic Ointment (topical) for wound healing

Tylenol (oral) as directed on bottle

Ibuprophen (oral) as directed on bottle

Cough Drops for coughing, minor throat irritation as needed

Antacid Tablet (oral) for stomach discomfort

Benadryl (oral or topical) for swelling, hives, allergic reaction as directed on bottle

Calamine Lotion or Cortaid (topical) for insect bites/bee stings

Visine/ Murine Plus Eye Drops (topical in eye) for minor eye irritation

Other (please describe) ____________________________

PHYSICIAN CONSENT

Physician Signature ____ **Date** _______________________

Printed Name ____ **License Number** ______________

Address ____**Phone** ________________________

City ______________________________ **State** ________ **Zip** _______ **Fax** _______________________

ALL PAGES OF PHYSICAL FORM NEED DOCTOR'S SIGNATURE.

Return all forms to:

Lancaster Presbyterian Church, 5461 Broadway St., Lancaster, NY, 14086