Lancaster Presbyterian Church

Name_____

Office Use Only

☐ Elementary Cabin #_____
☐ Intermediate Tent #_____
☐ Junior High Lodge or Cabin #_____

Dates of Camp: Thursday, June 27 – Wednesday, July 3, 2019

Physician's Report

Summer Youth Camp 2019

Name of Camper: _____

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

Physical Examination

List all immunizations given. Provide the **month and year for each immunization**. All immunizations must be current.

System	Within Normal Limits	Abnormal	Details/Explanation
Head/Neck			
Ears, Nose, Throat			
Lungs			
Heart			
Abdomen			
Genitalia			
Spine			
Extremities			
Neuro			
Skin			
Eyes			

Hospitalization History

Has the child been hospitalized within the past 3 years?

☐ Yes – If yes, please explain reasons, details and dates of hospitalization in chart below.

☐ No

Reason	Details	Dates

_____

Signature of Physician _____Date_____

Print Name or Stamp _____

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Physician's Report

Summer Youth Camp 2019

Name of Camper: _____

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

Immunization History

List all immunizations given. Provide the **month and year for each immunization**. All immunizations must be current.

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					
Other (Please specify)					

Tuberculosis History

Has the child been tested for Tuberculosis (TB)?

☐ Yes – If yes, please explain reasons, details and dates of hospitalization in chart below.
☐ No

If Yes, test Date: _____/_____/_____ Result: Negative Positive
If positive, please explain: _____

_____

Signature of Physician _____Date_____

Print Name or Stamp _____

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

Medication Information

Please list all medications (including over the counter or non-prescription drugs) begin taken. Bring enough medication to last the duration of the camp. Keep medications 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

Allergy Information

List all know allergies including the reaction to and treatment for the allergy.

☐ No known allergies

Allergy to	Reaction	Treatment

*All allergy medication (including epi pen, bee sting kit, lactose free milk, etc. must be brought to camp).

_____

Signature of Physician _____Date_____

Print Name or Stamp _____

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Summer Youth Camp 2019

Name of Camper: _____

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

Physicians Consent

Physician Signature _____ Date _____

Printed Name _____ License Number _____

Address _____Phone _____

City _____ State _____ Zip _____ Fax _____

Signature of Physician _____Date_____

Print Name or Stamp _____