CAMPER'S NAME _____

PHYSICIAN 1 Must fill out PHYSICIAN 1 & 2

PHYSICAL EXAMINATION & HEALTH HISTORY

IMMUNIZATION HISTORY

You MUST record the specific date (month and year) of basic immunizations and most recent booster doses

_____ DPT or DT
_____ MMR
_____ Other tetanus
_____ Polio vaccine (most recent)
_____ Tuberculosis
_____ Pneumonia vaccination
_____ Hepatitis B
_____ Recent exposure to contagious disease
_____ Haemophilus influenza type B
_____ Varicella (chicken pox)

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose (ie: sports, school) is acceptable; please provide copy. Examination is for determining fitness to engage in activities.

CODE: (blank) = Satisfactory **X = Not Satisfactory** **0 = Not examined**

Height _____
Weight _____
Blood pressure _____
Eyes _____
Glasses _____
Extremities _____
Ears _____
Nose _____
Throat _____
Teeth _____
Heart _____
Abdomen _____
Posture (spine) _____
Skin _____
Lungs _____
Hernia _____
General appraisal _____

RECOMMENDATIONS/RESTRICTIONS WHILE AT CAMP

Special diet _____
Swimming _____
Other _____

FOR GIRLS:

Has this person menstruated? _____
If not, has she been told about menstruation? _____
If so, is her menstrual history normal? _____

HEALTH HISTORY

List any medical problems, behavior problems, operations, serious injuries or special considerations

Asthma *Treatment* _____ *Last episode* _____
Seizures *Treatment* _____ *Last episode* _____
Insect Stings _____
Diabetes *Treatment* _____
Bedwetting *Treatment* _____ *Last episode* _____
Sleepwalking _____

Drug Allergies—specify	Food Allergies—specify	Environmental Allergies—specify	Other Allergies/Insect Stings

Mental, Emotional and Social Health. ***Check "Yes" or "No" for each statement.***

Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (ADHD)? ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
4. Had a significant life event that continues to affect the camper's life? ☐ Yes ☐ No

Please explain "Yes" answers on a separate sheet of paper, noting the number of the question.

The camp may contact you for additional information.

Cornell University Cooperative Extension Nassau County

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5 Old Jericho Turnpike
Jericho, NY 11753

516-433-7970
Fax 516-433-7971

Nassau@cornell.edu
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CAMPER'S NAME _____

PHYSICIAN 2 Must fill out PHYSICIAN 1 & 2

NOTE: The Department of Health requires that your child's physician complete the PHYSICIAN 2 form in order for your child to receive any of the over-the-counter medication that is available in the Health Lodge. If a licensed health care provider does not sign this form, the camper will not be given any prescription or over-the-counter medication. Please allow your health care provider ample time to complete this form and return it to us.

HERE ARE EXAMPLES explaining why YES MUST BE CIRCLED and the form MUST BE SIGNED by the physician:

- If your child gets a bug bite and it itches, the nurse can administer Caladryl only if YES is circled and the form is signed.
- If your child has nasal congestion, the nurse can administer Sudafed only if YES is circled and the form is signed.
- If your child gets a cut, the nurse can administer an antiseptic only if YES is circled and the form is signed.

HEALTH CARE RECOMMENDATIONS: Complete with patient's current regimen for both scheduled and prn medications—use 2nd page if needed. Bring all regularly taken prescriptions to the camp nurse when registering on the first day of camp.

DRUG NAME	ROUTE Circle preferred formulation	DOSAGE	SCHEDULE AND INDICATIONS	HEALTH CARE PROVIDER ORDER	COMMENTS
PRESCRIPTION MEDICATIONS					
OTC MEDICATIONS					
Anti-acid (Tums)	PO (pills or liquid)	Per label instruction by age/weight	Q 2-4 hrs PRN-Gas, heartburn, indigestion, stomach upset	Yes No	
Antifungal cream/ spray/powder	Topical (cream, spray, powder)	Per label instructions	PRN Athletes foot, jock itch	Yes No	
Antiseptics (Alcohol, Peroxide, Bacitracin)	Topical (cream or liquid)	Per label instructions	PRN Stings/bites, cuts, scrapes, splinters, blisters	Yes No	
Benadryl/Claritin	PO (elixir, chewable tabs or pills)	Per label instruction by age/weight	Q 6 hrs PRN for allergic reaction (hives, insect bite)	Yes No	
Caladryl, Hydrocortisone	Topical (cream or gel)	Per label instructions	Q 6-8 hrs PRN Rash, skin irritation, insect bites	Yes No	
Cough drops, throat spray	PO (lozenges, spray)	Per label instruction by age/weight	PRN Cough, sore throats	Yes No	
Delsym/Robitussin/ Robitussin DM	PO (liquid)	Per label instruction by age/weight	Q 4 hrs PRN Coughs	Yes No	
Ear drops	Otic (liquid)	Per label instructions	PRN – Swimmers ear	Yes No	
Ivy Block and Tecnu	Topical (cream)	Per label instructions	Q 4 hrs PRN Contact with poison ivy	Yes No	
Lysine	PO (Chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN pain, fever, cold symptoms, toothache, muscle aches	Yes No	
Ibuprofen/Tylenol	PO (Chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN pain, fever, cold symptoms, toothache, muscle aches		
Orasol, Anbesol and Abreva	Topical (liquid or cream)	Per label instructions	Q 6 hrs PRN – Oral herpes, cold sores, toothache	Yes No	
Pepto-Bismol	PO (liquid or chewable tabs)	Per label instructions	Q 30 minutes to 1 hr PRN for diarrhea (no>8 doses/24 hours)	Yes No	
Sudafed/ Pseudoephedrine	PO (Chewable tabs, pills or liquid)	Per label instruction by age/weight	Q 4-6 hrs PRN – Nasal/Sinus congestion, hay fever, allergies	Yes No	
Visine	Optical (liquid)	Per label instructions	PRN- Eyestrain, eye irritation	Yes No	

A PHYSICIAN, PHYSICIANS ASSISTANT OR NURSE PRACTITIONER MUST SIGN THE STANDING ORDERS

Camper's health care provider's name (please print) _____

Licensed physician's name (please print) _____

Licensed physician's signature _____ License # _____

Address _____ Phone ( ) _____

Date of form completion _____ By _____

Initial if completed by nurse or physician's assistant