



Deaf Teen Adventure Camp - Camper Physical Exam Form

This must be completed and signed by the participant's primary licensed healthcare provider. This form verifies the date of child's last physical (must be within 24 months of camp start date) and healthcare provider recommendations for participation in the camp program.

TO EXAMINING LICENSED PROVIDER: DTAC camp programs are physically and mentally strenuous at times. An individual with normal mental and physical capacity can usually expect to do well in our programs. Examples of activities in our programs include, but are not limited to, swimming, canoeing, rock climbing/rappelling, traversing varied terrain, exposure to the natural elements and using challenge courses of 50' high or greater. The camper must be able to safely get from one place in camp to another without being with or requiring another camper/staff. We appreciate your input as to whether there is any need for further evaluation, specific recommendations, or limitations for this participant in our program.

Name of Participant: _____ Date of Birth: _____ Date of Exam: _____

Health History (please check all that apply)

Allergies: None Drug Food Stinging Insect Other **Epi-Pen Required?** Yes No
Specify Allergen & Describe Reaction: _____

Asthma: Yes No Type: _____ Well Controlled? _____ Inhaler? Yes No

For participants prescribed epi-pens or inhalers: Please complete and sign the attached **Emergency Medication Permission Form** (page 2)

Significant recent illness, injuries/fractures, concussions, seizures, headaches, bowel or bladder issues): _____

Chronic Medical Conditions: _____

Does the participant have any Developmental/Social/Emotional History (examples: anxiety, depression, suicidal ideation, ADHD, ASD, bedwetting, IEP or 504)? No Yes If yes, please describe: _____

Does the participant have a Vision or Hearing Impairment? No Yes If yes, please describe: _____

List Hospitalizations and/or Surgeries: _____

Restrictions: Are there any active concerns or restrictions which would preclude this child from participating fully in a recreational program at camp? (diet, medical, swimming, physical, psychological): None Yes (please explain): _____

Medications*

List ALL medications (including over-the-counter, sleep aids/vitamins/supplements, prescription, etc.) the camper will be taking at camp.

Medication Name	Dose (mg)	Frequency/Time(s)	Reason

Immunizations

Date of last Tetanus Immunization: _____ Please attach an up-to-date immunization record.

TB Risk Assessment: Low Risk ___ High Risk ___

(Test not necessary if deemed low risk) Test Results: _____ Date of Test: _____

The above-named person has been determined to be physically and emotionally fit to participate in camp and camp activities without restrictions except as noted above.

Licensed Provider Signature (Required) _____ Date: _____

Licensed Provider Name (printed): _____ How long have you known camper? _____

Office Address: _____ Telephone: (____) _____

DTAC – Permission to Possess and Use Emergency Medications

Must be signed by a Licensed Healthcare Provider and Guardian

Licensed Healthcare Provider: Please complete this form if the participant is prescribed a rescue inhaler, EpiPen, or other emergency medication that they will be bringing to camp. In addition to this form, the participant must provide an extra medication dose/device to be kept at the Health Center for back up and/or emergencies.

Name of Participant: _____ **Date of Birth:** _____

Diagnosis requiring Emergency Medication: _____

Other Medical Conditions: _____

Medication Order

Medication Name: _____ Date of Medication Order: _____

Route and Dose: _____

Frequency/Time: _____

1. Does the participant need assistance with administration? No Yes If yes, please describe:
2. Specific recommendations for administration (list symptoms that would indicate need for medication):
3. List side effects, contraindications and or adverse reactions to be observed if the medication is administered:
4. Provide recommendations for care after medication is administered (ie: Health Team observation? How long? Return to activity after _____ amount of time):
5. Action plan is attached: Yes No

As this participant's provider, I give permission for this participant to possess and use the above medication. This participant has the knowledge and skills to safely possess and use the medication in a camp setting during DTAC Camps and programs.

Licensed Provider Signature (Required) _____ **Date:** _____

Licensed Provider Name (printed): _____

Office Address: _____ Telephone: (____) _____

Parent/Guardian Section

I will provide a second dose of this medication to be kept at the Health Center for emergencies.

As the legal guardian of the above listed child, I grant permission to the Deaf Teen Adventure Camp to allow my child to have readily available (carry or possess outside of the regular supervision of the healthcare staff) and self-administer, as medically necessary, the medications listed below.

Parent/Guardian Signature: _____ **Date:** _____

Print Name: _____ Relationship to participant: _____