Camp Nock-A-Mixon Physician's Form

Please have your child's health-care provider complete this form.

Camper's Name:____

☐ Male Date of Birth:____________________ (mm/dd/yy)
☐ Female

Camper's Home Address:____

____

The following non-prescription medications are commonly stocked in the camp health center and are used on an as needed basis.

Please cross out any items the camper should NOT be given

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Phenylephrine (Sudafed PE)
Chlorpheniramine maleate
Guaifenesin
Dextromethorphan
Diphenhydramine (Benadryl)
Generic cough drops
Chloraseptic (Sore throat spray)
Lice shampoo or scabies cream
Bismuth subsalicylate (Pepto-Bismol)
Laxatives for constipation
Hydrocortisone 1% cream
Topical antibiotic
Aloe
Calamine Lotion

Date of Physical exam:________________ (mm/dd/yy)

Weight:_________ lbs Height:______ft______in

Blood Pressure: ________ / _________

Allergies:

☐ No Known Allergies
☐ To Foods (list):
☐ To medications (list):
☐ To the environment (insects, hay, etc. -list):
☐ Other allergies (list):

Diet & Nutrition:

☐ Eats a regular diet.
☐ Has a medically prescribed meal plan or dietary restrictions (describe):

Is the camper undergoing treatment for any conditions at this time?

☐ No
☐ Yes (describe)

Medications:

☐ No daily medications
☐ Will take the following prescribed medication(s) while at camp (name, dose, frequency)

Are there any other treatments/therapies to be continued at camp?

☐ No
☐ Yes (describe)

Do you feel this camper will require limitations or restrictions to activity while at camp?

☐ No
☐ Yes (describe)

I have discussed the camp program with the camper's parent/guardian. It is my opinion that the camper is physically and emotionally fit to participate in an active camp program.

Physician name:______________________________ Physician's Signature______________________________

Office Address:____

Office Telephone:______________________________ Date:______________________ (mm/dd/yy)