

# 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 circle any items the camper should NOT be given**

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

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)