Camp Physical

girl scouts of texas oklahoma plains

To Parent(s)/ Guardian(s): Complete this section and give this form to your child's health-care provider for review.
Dates will attend camp: from _____ (Month/Day/Year) to _____ (Month/Day/Year)

Camper Name: _____ (First) (Middle) (Last)

☐Male ☐Female Birth Date _____ (Month/Day/Year) Age on arrival at Camp _____

Camper home address: _____

_____ (City) (State) (Zip Code)

Custodial parent(s) phone: (_____) _____ (_____) _____

Parent(s)/ guardian(s) stop here. Rest of form to be completed by medical personnel.

The following non-presciption medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. **Medical personnel: Cross out those items the camper SHOULD NOT be given.**

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Phenylephrine (Sudafed PE)
Pseudoephedrine (Sudafed)
Chlorpheneramine maleate
Guaifenesin
Dextromethorphan
Diphenhydramine (Benadryl)
Generic Cough Drops
Chloraseptic (sore throat spray)
Lice shampoo or scabies cream (Nix or Elimite)
Calamine Lotion
Bismuth subsalicylate (Pepto-Bismol
Laxatives (Ex-Lax)
Hydrocortisone 1% Cream
Topical Antibiotic Cream
Aloe Vera

Physical Exam done today: Yes No

(if "No," date of last physical _____ (Month/Day/Year)

ACA accredition standards specify physical exam within the last 12 months.

Weight _____ lbs Height ___ft___ in

Blood Pressure ___/___ Allergies: ☐ No Known Allergies

- ☐ To Food (list)
- ☐ To Medications (list)
- ☐ To the Environment (insect stings, hay fever, etc.- list)
- ☐ Other Allergies (list)

Describe previous reactions:

Diet. Nutrition: ☐ Eats a regular diet. ☐ Has a medically prescribed meal plan or dietary restricitons: (describe below)

The camper is undergoing treatment at this time for the following conditions: (describe below) None.

Medication. No daily medications. Will take the following prescribed medication(s) while at camp: name, dose, frequency- describe below)

Other treatments/therapies to be continued at camp: (describe below) ☐ None needed.

Do you feel that the camper will require limitations or restrictions while at camp? No Yes

If "Yes" to the question above, what do you recommend? (describe below-attach additional information if needed)

"I have reviewed the Camper's health, and have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active program (except as noted above.)"

Name of licensed provider (please print): _____ **Signature:** _____ **Title:** _____

Office address _____ (Street) (City) (State) (Zip Code)

Telephone: _____ **Date:** _____