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Physician's Report 2019

Your physician must complete both sides of this form. Please keep in mind that only relevant information will be shared. All information will be held in strict confidence and given proper attention. Please have this form returned to the camp office by June 1, 2019. (Please note that a camper or an employee will not be permitted to attend camp without this form on file before their first day)

Name _____ Date _____

Address _____ Phone Number _____

Sex: M F Date of Birth _____ Grade entering in September 2019 _____

Height _____ Weight _____ Blood Pressure _____ Urine _____

Physician's Health Care Recommendations

Date of examination _____

Examination is acceptable when performed after August 22, 2018

This person is physically qualified to participate in the following categories of competition:

- Contact/Collision Including: Field Hockey, Football, Lacrosse, and Soccer
- Limited Contact/Impact Including: Baseball, Basketball, Diving, Gymnastics, Softball, Volleyball
- Strenuous Noncontact Including: Cross-Country, Track and Field, Swimming, Tennis, Zip-line
- Non-strenuous Noncontact Including: Archery, Bowling

This person is under the care of a physician for the following condition(s):

Current treatment (include current medications):

Treatment(s) to be continued at camp:

Medication(s) to be administered at camp:

Allergies: YES NO

If YES, is reaction LIFE THREATENING: YES NO UNSURE

If YES....

Is it to: Food Medication Plant Insects Other (please list). _____

Please List Allergens: _____

Describe REACTION: _____

Describe Treatment/Management: _____

(If there is an anaphylactic response, please supply an epi pen to keep in the health office.)

A MEDICATION AUTHORIZATION FORM and FARE FORM will need to be filled out by both the parent and physician.

Camper's Name _____

Health History:

Cardiovascular condition: <input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal condition: <input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory condition: <input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological conditions: <input type="checkbox"/> Yes <input type="checkbox"/> No
Middle ear condition: <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic conditions: <input type="checkbox"/> Yes <input type="checkbox"/> No

** If "Yes" was answered to any of the conditions above, please give an explanation and details on a separate piece of paper.*

Immunization History:

Please record the date (month and year) of basic immunizations and most recent booster doses.
(An attached physician's office printout is acceptable)

Vaccine	Date Each Dose Was Given						
	1st	2nd	3rd	4th	5th	6th	7th
DTaP/DT/Td							
HIB							
Polio							
Pevnar							
Hep B							
MMR							
Varicella							
Hep A							
HPV							
Rotavirus							
Meningococcal							

Additional medical or psychological conditions not listed that we should be aware of? _____

We may have neglected to ask something you feel is needed to adequately address the health needs of this person. If that is the case, please add your comments. _____

This is to certify I have examined the individual above, reviewed their health history and it is my opinion that they are physically able to **participate in all** summer camp activities at Buckley Day Camp with no restrictions.

Licensed Physician's Signature _____

Physician's Printed Name _____ Physician's Stamp _____

Physician's Address _____ Phone _____

Please note this form is optional

To be completed by your physician for all campers and staff less than 18 years old
Parents, please initial

Name _____

Standing Orders for Over-The-Counter Medications

The physician must complete this form if you would like us to administer any of the following over-the-counter medications in camp.

IMPORTANT - Parent/Guardian: Please read below and initial here _____.

Your physician must complete this form by checking "yes" or "no" on each line and signing at the bottom. By New York State law, we cannot administer over-the-counter medications unless both this form and the Physician's Report are properly completed and signed by the physician. A doctor's order of "no" with no alternative listed alongside it means that we cannot administer that medication to your child, no matter how badly it is needed. Please ask your doctor to take the time to complete this form thoroughly. If necessary, you can complete the form and ask your doctor to verify and sign off on it, but we must have this permission from your child's doctor in order to administer over-the-counter medications.

The following medications can be administered by a camp nurse if approval is indicated by the child's physician. The physician MUST note on this form, the route of administration, dosage, and schedule of each medication they are saying YES to. Generic equivalents of name brands may also be administered; please indicate if a child has an allergy to a specific generic or name-brand drug.

Drug Name	Doctor's Order	Special Instructions for Administration or Alternate Medication
Ibuprofen	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tylenol	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Benadryl	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hydrocortisone Cream/Ointment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Saline / Eye Wash	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Licensed Physician's Signature _____

Physician's Printed Name _____ Physician's Stamp _____

Physician's Address _____ Phone _____