To Be Completed by your Physician

Physician's Report 2020

BUCKLEY day camp
2 I.U. Willets Road
Roslyn, NY. 11576
516 365-7760
Fax 516 869-0964
www.buckleycamp.com

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, 2020. (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 2020 _____

Height_____ Weight_____ BloodPressure_____ Urine_____

Physician's Health Care Recommendations

Date of examination_____
Examination is acceptable when performed after August 22, 2019

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 FORMand FARE form* will need to be filled out by both the parent and physican.

Name:_____

Health History:

Cardiovascular condition: □ Yes□ No	Gastrointestinal condition: □ Yes□ No
Respiratory condition: □ Yes□ No	Neurological conditions: □ Yes□ No
Middle ear condition: □ Yes□ No	Orthopedic conditions: □ Yes□ 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							
Prevnar							
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 intial

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	□ Yes □ No	
Tylenol	□ Yes □ No	
Benadryl	□ Yes □ No	
Hydrocortisone Cream/Ointment	□ Yes □ No	
Saline / Eye Wash	□ Yes □ No	
Other: _____	□ Yes □ No	

Licensed Physician's Signature _____

Physician's Printed Name _____ Physician's Stamp_____

Physician's Address _____ Phone_____