CHILDREN'S BIBLE FELLOWSHIP OF NY, INC

Camp Hope/Camp Joy 2017 Physical Examination

Date of PHYSICAL: _____ /_____ / _____
Month Day Year

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ /_____ /_____
Month Day Year

HIPPA Privacy Statement: Permission to release confidential health information. I give the medical practice listed below permission to release confidential health information to Children's Bible Fellowship (Camp Joy/Camp Hope) regarding the individual listed above.

_____ Date: _____ /_____ / _____
Signature of parent, guardian, adult participant Month Day Year

HISTORY/ SCREENING/ TEST RESULTS

Physical Exam	✓	Comments	Physical Exam	✓	Comments	Physical Exam	✓	Comments
Height:			Head/Scalp			Neck		
Weight:			Eyes			Heart		
Blood Pressure: ____ /____			Ears			Lungs		
Pulse:			Nose			Abdomen		
Tests:			Throat			Genitalia		
Allergies:			Mouth/Teeth			Ano/Rectal		
Diet:			Glands			Extremities/Hips		
			Neuro			Skin		

Additional Comments:

For individuals with special needs: List diagnosis/es:

TB: In high risk group? YES NO

TB & other test results (sickle cell, etc.)

Test	Date	Result

DISEASE ASSESSMENT

Condition				**Date of Onset**
Asthma	YES	NO	MILD MODERATE SEVERE EXERCISE INDUCED	
Diabetes	YES	NO	TYPE I TYPE II	
Anaphylactic Reaction	YES	NO	FOOD INSECT LATEX OTHER: (Explain)	
Seizure Disorder	YES	NO	TYPE:	
Chickenpox	YES	NO	IF YES, WHEN?	
Mumps	YES	NO	IF YES, WHEN?	

Other: Please specify.

Prescription Medication: (Patient's current regimen for both scheduled and PRN medications. Please use additional paper if needed.)

Drug	Route	Dosage	Frequency	Comments

Individualized orders (MUST BE COMPLETED) These standard over-the-counter/PRN medications are available in the Health Center to be administered if needed per family physician's instructions. ***Please be aware that CBF cannot administer any medication, including over-the-counter, without a Doctor's signature.***

Drug Name (generic equivalents may be used)	Dosage	Route	Indications	Healthcare Provider Permission: If provider has not checked "NO", it means "YES"	Comments
Diphenhydramine	As per pkg. by wt. & age	PO	Allergies/ Allergic reactions	[ ] YES [ ] NO	
Burn Gel	As per pkg. by wt. & age	Topical	Minor Burns	[ ] YES [ ] NO	
Acetaminophen	As per pkg. by wt. & age	PO	Temp. ≥ 100◦ F or Pain	[ ] YES [ ] NO	
Ibuprofen	As per pkg. by wt. & age	PO	Temp. ≥ 100◦ F or Pain	[ ] YES [ ] NO	
Aleve	As per pkg. by wt. & age	PO	Temp. ≥ 100◦ F or Pain	[ ] YES [ ] NO	
Hydrocortisone	Apply to affected area 3X a day	Topical	Itch	[ ] YES [ ] NO	
Calamine	Apply to affected area 3X a day	Topical	Itch	[ ] YES [ ] NO	
Antibiotic Ointment	Apply to affected area 3X a day	Topical	Scrapes or Cuts	[ ] YES [ ] NO	
Ivarest Cream	Apply to affected area 3X a day	Topical	Rash from ivy, oak, sumac	[ ] YES [ ] NO	
A&D Ointment	Apply to affected area 3X a day	Topical	Diaper Rash	[ ] YES [ ] NO	
Advil Cold + Sinus	As per pkg. by wt. & age	PO	Common Cold	[ ] YES [ ] NO	
Dayquil	As per pkg. by wt. & age	PO	Common Cold	[ ] YES [ ] NO	
Nyquil	As per pkg. by wt. & age	PO	Common Cold	[ ] YES [ ] NO	
Dimetapp Cold	As per pkg. by wt. & age	PO	Common Cold	[ ] YES [ ] NO	
Vitamin C	As per pkg. by wt. & age	PO	Common Cold	[ ] YES [ ] NO	
Cough Drops	As per pkg. by wt. & age	PO	Cough or Sore Throat	[ ] YES [ ] NO	
Antacid	As per pkg. by wt. & age	PO	Upset Stomach	[ ] YES [ ] NO	
Maalox	As per pkg. by wt. & age	PO	Indigestion	[ ] YES [ ] NO	
Kaopectate	As per pkg. by wt. & age	PO	Diarrhea	[ ] YES [ ] NO	
Stool Softener	As per pkg. by wt. & age	PO	No BM X 2 days	[ ] YES [ ] NO	
Milk of Magnesia	As per pkg. by wt. & age	PO	No BM X 2 days	[ ] YES [ ] NO	
Fleet Enema	As per pkg. by wt. & age	Rectal	No BM X 3 days	[ ] YES [ ] NO	

LAST NAME: _____ FIRST NAME: _____

Emergency Medications			
Does individual require an Epi-pen?	[ ] YES	[ ] NO	
If YES, does individual have permission to carry?	[ ] YES	[ ] NO	[ ] Not Applicable
Does individual require a PRN Inhaler?	[ ] YES	[ ] NO	
If YES, does individual have permission to carry?	[ ] YES	[ ] NO	[ ] Not Applicable

Additional Orders: As deemed necessary by care provider (e.g. BP checks, glucose monitoring, dressing changes, cast care, bedrails, etc.)

Limitations or special instructions on activities: (Camp Joy is a typical sleep-away camp, Camp Hope is a sleep-away camp adapted for individuals with special needs.) **Please explain any limitations or special instructions below:**

Swimming:_____ Diving:_____ Hiking:_____ Athletics:_____

Other:

ATTATCH REQUIRED IMMUNIZATION HISTORY

Children and adults to age 25: Please attach a complete copy of all immunizations (month/date/year). Campers/staff will not be allowed to attend camp

If over age 26, only dates of last tetanus booster within last 10 years are required, and meningococcal vaccine is recommended.

Age 26 or over: Date of last tetanus booster: _____ / _____ / _____
Month Day Year

Age 26 or over: Date of last meningococcal: _____ / _____ / _____
Month Day Year

I certify that I have examined the above named individual and that on the basis of my examination and the medical history as furnished to me, have found no reason which would make it medically inadvisable for this individual to participate in physically strenuous activities, except as listed in limitations above.

_____ Date: _____ / _____ / _____
Physician's Signature Month Day Year

Please print or stamp:

Physician's Name _____

License Number _____

Address _____

Phone _____

Fax _____

LAST NAME: _____ FIRST NAME: _____