CAMP PHYSICAL FORM

Name_____ Date of Birth____/____/____ Age_____

Address_____ City_____ State_____ Zip_____

Parent/Guardian 1_____ Phone_____

Parent/Guardian 2_____ Phone_____

MEDICAL HISTORY

Allergies	Yes / No	_____
Hospitalizations or Surgeries	Yes / No	_____
Bone or Joint Injuries	Yes / No	_____
Diabetes	Yes / No	_____
Significant Previous Injuries	Yes / No	_____
Seizures	Yes / No	_____
Asthma	Yes / No	_____
Glasses or Contacts	Yes / No	_____
Fainting/Dizzy Spells	Yes / No	_____
Current Vaccinations	No / Yes	_____

Other _____

PARENT NOTE

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION Per the RULES REGULATING CHILDREN'S RESIDENT CAMPS in the State of Colorado, section 7.711.5 CHILD CARE and section 7.711.51 Health Care:

"The health care provider shall administer only medicines prescribed for an individual camper or medicines listed in written standing treatment procedures from a licensed physician who has agreed to furnish medical services for the camp, pursuant to Section 7.711.61, A.

Such medicines shall only be administered by authority of written authorization given to the camp or to the health care provider by the child's physician or camp physician.

Medication prescribed for campers shall be from a licensed pharmacy; labeled with the name, address, and phone number of the pharmacy; name of the camper; name and strength of the medicine; directions for use; date filled; prescription number, and, the name of practitioner prescribing the medicine.

I hereby request that Treasure Mountain Bible Camp's Health Care Provider administer the medication(s) as directed by this form. I understand that it is my child's responsibility to report to Nurses Station at camp for this service. I authorize the release of information between Treasure Mountain Bible Camp and the Physician pertinent to my child's medication(s). I also acknowledge that all my camper's medications must be in the prescription of manufacturer's container to be given at camp.

Parent Signature_____ Date_____

PHYSICAL EXAM

(to be completed by the physician)

Height_____ Weight_____ Vital Signs_____

Feature	Normal	Abnormal	Comments
General			
Eyes			
Nose			
Dental/Mouth			
Throat			
Ears			
Skin			
Cardiovascular			
Musculoskeletal			
Neurological			
Genitourinary			
Gastrointestinal			
Spinal			
Nutritional Status			
Mental Health			

Additional Comments_____

_____

_____

MEDICATIONS

Medication	Dosage	Frequency	Time	Comments

Inhaler/ Epi-Pen Exception: This child may carry his/her inhaler/Epi-Pen and self-administer as needed. This child has been instructed in the proper use of the above identified medication. (Please circle appropriate medication)

Physician_____ **Office**_____

Signature_____ **Date**_____