Treasure Mountain Bible Camp

Marble, Colorado

Camper/Counselor Physical form to be completed by a physician

Physical are good for two years. Can use a copy of Sports Physical. Registration is void without these forms completed.

I have examined _____on _____and found him/her to be in satisfactory physical condition and capable of participation in a regular Residential Camp Program except for the following:_____.

Physical Problems: _____.

Special Care_____.

***Physicians Name:**_____Address_____

City:_____ State:_____ Zip:_____ Phone #_____e-mail_____

***Physicians Signature:**_____ Date:_____

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.

Physicians Authorization for administration of medication for the camper: I hereby authorize the properly qualified health supervisor of Treasure Mountain Bible Camp to administer the following medications (which includes over-the-counter medications:_____

***Physicians Signature:** _____Date_____

TO BE COMPLETED BY THE PHYSICIAN: ***(this includes over-the-counter and prescription medications)***

1. Medication:_____ Dosage: _____ Route: _____
   Frequency: _____ Purpose: _____
   Length of treatment:_____
2. Medication:_____ Dosage: _____ Route: _____
   Frequency: _____ Purpose: _____
   Length of treatment:_____
3. Medication:_____ Dosage: _____ Route: _____
   Frequency: _____ Purpose: _____
   Length of treatment:_____
4. 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)*

NAME OF PRESCRIBING PHYSICIAN(s)_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE_____e-mail_____

PHYSICIAN'S SIGNATURE:_____DATE: _____
TO BE COMPLETED BY PARENT/GUARDIAN:

☝Parent Note: Camper medications must be in the prescription or manufacturer's container.

"I request that Treasure Mountain Bible Camp's Health Care Provider administer the medication(s) as directed above.
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)."

PARENT/GUARDIAN'S SIGNATURE:_____DATE:_____