HEALTH EXAMINATION FORM

For Campers

Parents return all forms before 6/1/24

Forms dated ON or After 9/1/23 will be accepted.

- ○ **Section 1**
- ○ **Section 2**
- ○ **Immunization Record**
- ○ **Asthma or Allergy Action Plan (if needed)**

INDIAN SPRINGS DAY CAMP
1540 Street Road
Chester Springs, PA 19425

Email: indiansp@indianspringsdaycamp.com

Section 1: to be filled out by parent/guardian and checked by physician at time of examination.

Name _____ Birth Date _____ Sex: M / F Age_____
Last First MI

Parent or guardian

1. _____ Phone # _____
2. _____ Phone # _____

Other emergency contacts:

1. _____ Phone # _____
   Name/Relationship
2. _____ Phone # _____
   Name/Relationship

Family Physician: _____ Phone # _____

Medical Insurance _____ Policy # _____

Parent Assessment of Camper's Health:

IMPORTANT: Please notify the camp if camper is exposed to any contagious illness 2 weeks prior to camp attendance.(Examples: chicken pox, COVID, diarrhea, influenza, measles, etc.)

Chronic or Recurring Illness(es):_____

_____

Behavioral/emotional challenges that may impact camp experience: _____

_____

Specific activities to be restricted: _____

_____

Strategies for success at camp: _____

_____

If necessary, use back of this page for additional information

PARENT'S AUTHORIZATION I have completed this page and reviewed the attached medical documents and all is correct so far as I know. The person herein described has my permission to engage in all prescribed activities, except as noted by me and the examining physician. I authorize Indian Springs Camp staff to administer medications as indicated in writing by my child's physician. In the event I cannot be reached in an emergency, I hereby give permission to the medical professional selected by the camp director to hospitalize, secure proper treatment for, order injection, anesthesia or surgery for my child as named above. **Parent Signature** _____ **Date:** _____

Camper Name _____ Birth Date_____

SECTION 2: TO BE FILLED OUT BY CAMPER'S PHYSICIAN

HEALTH HISTORY/MEDICAL EXAM:

Please attach copy of the immunization record.

Does this child have health conditions of any kind, (including physical, psychiatric, or behavioral), which camp staff should be made aware of?

☐ No ☐ Yes, Please explain: _____

Vision OK: ☐ Yes ☐ No ☐ Wears glasses ☐ Contacts

Hearing OK: : ☐ Yes ☐ No ☐ Uses Hearing Aids

Full use of arms: ☐ Yes ☐ No

Fully Ambulatory: ☐ Yes ☐ No

ALLERGIES: None: ____ Yes ____ Please specify: _____

Severity: ☐ Mild ☐ Moderate ☐ Severe

Reaction: _____

Allergy Action Plan Attached: ☐ Yes ☐ No Note: this is required if medications are used to manage this allergy.

***Recommendations or Restrictions while in camp**.

☐ Special Diet: _____

☐ Swimming/Diving: _____

☐ Strenuous Activity/Heat Tolerance: _____

☐ Other: _____

Physician orders for medications to be taken during camp hours:

☐ This person takes NO medications.

This person takes medications as follows: (includes Insulin, Glucagon, Epipen, etc.), Attach additional pages as needed

Med #1 _____ Dosage _____ Route _____

Specific times each day _____ Reason for taking:_____

Med #2 _____ Dosage _____ Route _____

Specific times each day _____ Reason for taking:_____

Med #3 _____ Dosage _____ Route _____

Specific times each day _____ Reason for taking:_____

Med #4 _____ Dosage _____ Route _____

Specific times each day _____ Reason for taking:_____

Camper Name_____ Birth Date:_____

Physician Standing Orders for as needed over-the-counter medications to be taken during camp hours:

In the absence of a guardian to administer, Indian Springs staff require a physician's order before treating a minor with over-the-counter medications. With your order AND parent/guardian permission, Indian Springs Staff would like to be able to treat your patient with over-the-counter medication for a minor sore throat, headache, fever lasting less than 24 hours, muscle ache, abrasions, seasonal allergy symptoms or mild allergic reactions. The Parent/Guardian will be notified about any illness requiring medication. All medications are dispensed as ordered. Please complete the following medication orders to authorize their use. For special orders, please write your instructions in the space provided by indicating the drug, dosage, route, time, duration, and appropriate use for such administration.

1. Diphenhydramine _____mg PO every_____hours PRN for mild allergy symptoms or reactions.

2. Acetaminophen _____mg PO every_____hours PRN for mild pain or fever > 100.4°f. *(for fevers parent will be called to pick up camper)*

3. Ibuprofen _____mg PO every_____hours PRN for mild pain.

4. Additional medications/instructions: _____

_____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities, except as noted above. I have reviewed this patient's medication list and indicated any medications that will need to be administered during camp hours. I have reviewed the above list of over-the-counter medications and indicated the ones appropriate for this patient should the need arise.

Physician Signature:_____Date_____

Printed physician name_____Phone:_____

Address _____

_____