HEALTH EXAMINATION FORM

for Campers and Staff

ARROWHEAD DAY CAMP
240 Dutton Mill Road
West Chester, PA 19380-6601
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Parents return all forms by 6/10/22

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

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

Name ______________________________________ Birth Date__________Sex _____ Age ________
Last First Initial

Parent or guardian, (or spouse)

1. ______________________________________ Phone# ____________

2. ______________________________________ Phone# ____________

Other emergency contacts:

1. ______________________________________ Phone# ____________
Name//Relationship

2. ______________________________________ Phone# ____________
Name//Relationship

Family Physician: ______________________________ Phone# ____________

Medical Insurance: ______________________________ Policy No. ____________

Parent Assessment of Camper's Health:

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

Chronic or Recurring Illness(es): ______________________________

Behavioral or 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 Camp Arrowhead 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 physician selected by the camp director to hospitalize, secure proper treatment for, order injection, anesthesia or surgery for my child as named above.

Parent Siganature ______________________________ 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 OTC Medications to be taken during camp hours:

In the absence of a guardian to administer, Arrowhead staff require a physician's order before treating a minor with over-the-counter medications. With your order AND parent/guardian permission, Camp Arrowhead 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.**
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.

PhysicianSignature:____Date_________________

Printed physician name_______________________________________Phone:_______________

Address ____

____