HEALTH EXAMINATION FORM

for Campers and Staff

ARROWHEAD DAY CAMP
240 Dutton Mill Road
West Chester, PA 19380-6601
FAX: (610) 695-8118
email:chiefarrowhead@comcast.net

Parents return all forms by 6/10
- ❑ **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 _____

_____