NOTE: Use this form only, please. Other forms are not accepted. This exam must be completed after April 1st and before the start of camp.

MEDICAL EXAMINATION FOR FRIENDLY PINES CAMP-NOTE: PERSON MUST BE PHYSICALLY SEEN

MUST be completed by physician or Licensed Nurse Practitioner. _____

Name _____ Age _____ Height _____ Weight _____

Condition of Throat _____ Eyes _____ Ears _____ Sinuses _____ Teeth _____ Abdomen _____ Lungs _____

Blood Pressure Reading _____ Any Heart Disorder _____ Skin (Athlete's Foot, Impetigo, Ringworm, Etc.) _____

Orthopedic _____ Vision L _____ R _____ Correction-Glasses _____ Contact Lenses _____

Any known exposure to (or indication of) communicable disease currently? _____

Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) DPT Tetanus or	1 2 3	1 2
Tetanus Diphtheria TD or		
Tetanus		
Oral Polio (Sabin)*TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German Measles, 3-day measles)		
Other		
Tuberculin test given _____ (most recent)		
Haemophilus influenza b (HIB)		
Hepatitis B		

Any allergies (food, drugs, plants, insects, etc.) _____

_____

May this person be given Tylenol if needed? YES NO State preferred aternative: _____

This person is under the care of a physician for the following condition(s): _____

_____

* List medications being brought to camp: Name of Rx: _____ Used for: _____

Dr's. prescribed dosage: _____ Name of prescribing Dr.: _____ Phone: (____) _____

Any medications or treatments that should not be used: _____

Any medically prescribed meal plan or dietary restrictions: _____

_____

Suggestions for suitable substitutions, if necessary: _____

Is the staff member bringing any over-the-counter vitamins, minerals, medications, etc? NO YES (please attach list)

* If YES, please see note below.

Is there any reason why this person cannot participate in regular camp activities? NO YES If, YES: Restrictions; Comments; Recommendations: _____

Any additional health information: _____

_____

Date: _____ Name of Examining Physician: _____ M.D. D.O. L.N.P. Other: _____

(please print or type name) (Circle)

Phone: (___) _____ Signature: _____

Address _____

street & number city state zip

* PLEASE NOTE: For the safety of every person in camp, all medications must be kept under lock and key, whether in Nurse's possession or staff member's personal locker. Whether such medication is self-administered by the staff member him/herself, or by the nursing staff, will be at the discretion of the Camp Nurse. It is the staff member's responsibility to take medication in compliance with instructions indicated by his/her doctor. PLEASE LIST ABOVE ANY MEDICATION BEING BROUGHT TO CAMP, showing name of medicine, what it is for, and Doctor's recommended dosage. This information is necessary for the Camp Nurse's records and permanent file.

(For CAMP USE) This person's complete medical record, showing date, complaint, treatment and any other pertinent medical details are all recorded in the camp nurse's log for this season.

Signed _____ AZ R.N.# _____ Date _____