MEDICAL FORM

FILLED OUT BY PHYSICIAN ONLY

CAMP MARK SEVEN

144 MOHAWK HOTEL RD · OLD FORGE · NY · 13420

Name: _____ __Male __Female

First Middle Last

Birth Date _____ ___Hearing ___Deaf ___Hard of Hearing ___Has Cochlear Implant(s)

Month/Date/Year

DATE OF EXAMINATION: _____

MEDICAL HISTORY

GENERAL	ALLERGIES	DISEASES	OTHER
☐ Ear Infections	☐ Hay Fever	☐ Chicken Pox	☐ Usher's Syndrome
☐ Rheumatic Fever	☐ Poison Ivy, etc.	☐ Measles	☐ Paralysis
☐ Convulsion/Seizures	☐ Insect Stings	☐ German Measles	☐ Fears
☐ Diabetes	☐ Penicillin	☐ Mumps	☐ Operations
☐ Behavior/Emotional Disorders	☐ Food:	☐ Asthma	☐ ADD/ADHD
☐ Sleepwalking	☐ Medicine:	☐ Heart Condition	☐ Learning Disabilities
☐ Hearing Loss	☐ Other:	☐ Other:	☐ Bedwetting
☐ Other:	☐ Other:	☐ Other:	☐ Autism

PLEASE PROVIDE DETAILS TO QUESTIONS ASKED BELOW:

Operations or serious injuries (dates?) _____

Chronic or recurring illnesses? _____

Describe any items marked above: _____

STANDING ORDERS

These medications, stocked in the Infirmary, are used to help manage common illnesses or injury concerns and dispensed as directed via medical protocols signed by the Camp's medical staff. **Medical personnel: Cross out these items camper should not be given.**

Acetaminophen	Auro dri
Diphenhydramine	MuscleRub
Ivy Dry	Pseudoephredine
Guaifenesin	A & D ointment
Nix	Triple Antibiotic
Aloe	Cream Antiseptic Spray
GasX	Camphophenique
Afterbite Lotion	Solercaine
Caladryl Lotion	Milk of Magnesia
Ibuprofen	Hydrogen Peroxide
Tinactin	Antifungal ointment
Tums	Hydrocortisone Cream
Zyrtec	Pepto-Bismol
Claritin	Neosporin ointment
Cepecal	Bacitracin ointment/spray
Lozenges/Cetacine Spray	Rubbing alcohol
Emetrol	Anti-diarrhea medication
Hibiclens	Cough Syrup (Robitussin)
Visine-like eye drops	Kaopectate
Eye wash	Lopermide

PHYSICAL EXAMINATION

Height:	Weight:	Blood Pressure:
Pulse:	Respiration:	Head:
Eyes:	Glasses:	Ears:
Nose & Mouth:	Throat:	Chest:
Lungs:	Heart:	Teeth:
Abdomen:	Hernias:	Musculoskeletal:
Extremities:	Skin:	Lymphatic:
Neurological:	Development:	Other:

GIRLS ONLY: Has she menstruated? ☐ Yes ☐No

IMPRESSION:

MISCELLEANOUS

DIET & NUTRITION: ☐ Eats a regular diet ☐ Has a medically prescribed meal or dietary restrictions: (describe below or attach note)

MEDICATIONS: ☐ No daily medications ☐ ☐ Will take the following prescribed medication(s) while at camp: (name, dose, frequency – describe below or attach note)

OTHER TREATMENTS/THERAPIES TO BE CONTINUED AT CAMP: (describe below or attach note)

Do you feel that the camper will require limitations or restrictions to activity at camp? No Yes

If you answered "Yes" to the question below, what do you recommend? (describe below – attach additional information if needed)

It is my opinion that the camper is physically and emotionally fit to participate in an active program (except as noted above.) Date: _____

Licensed Provider Print Name: _____ Signature: _____ Title: _____

Office Address: _____ Telephone: _____