

MEDICAL FORM

FILLED OUT BY PHYSICIAN ONLY

CAMP MARK SEVEN

144 MOHAWK HOTEL RD · OLD FORGE · NY · 13420



Name: _____

☐ Male ☐ Female

Birth Date _____
First Middle Last
Month/Date/Year

☐ Hearing ☐ Deaf ☐ Hard of Hearing

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.**

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

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:

MISCELLANEOUS

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 above, what do you recommend? (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: _____