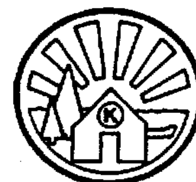
2017 Kamp Kiwanis®
Health Exam by a Physician



NO ES SUFICIENTE SUJETAR SU PROPIO REGISTRO DE SALUD, ESTE FORMULARIO DEBE SER COMPLETADO EN SU TOTALIDAD PARA ASISTIR EL KAMPAMENTO KIWANIS

Para ser completado por un Medico con Licencia, Asistente Medico, o Enfermera Practicante que representa al Medico con Licencia

2017 EXAMEN MEDICO (PARA SER COMPLETADO POR DOCTOR):

Name___________________________________Male/Female______DOB______________Height____________ Weight____________

BP________P________ Vision R20/_________L20/_________Ears___________Throat___________Teeth___________Skin___________

Respiratory________________ Cardiovascular_______________ Musculoskeletal________________ Neurological___________________

Liver___________ Spleen___________ Genitalia___________ Hernia___________ U/A____________ Asthma____________________

The patient is under the care of a physician for the following condition(s): ____

INDIVIDUALIZED ORDERS: The following non-prescription medications are commonly stocked in the Kamp Health Center and are used on an as needed basis to manage illness and injury.
Medical personnel: Cross out those items the camper should not be given.

- Aloe
- Antacids
- Auralgan (Ear Drops)
- Bismuth Subsalicylate (Pepto-Bismol)
- Calamine Lotion
- Chloraseptic (Sore throat spray)
- Chlorpheneramine maleate
- Cough Suppressants
- Decongestants (Sudafed & Sudafed PE)
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Guaifenesin (Robitussin any form)
- Laxatives for constipation
- Lice shampoo
- Pain reliever/fever reducer:Acetaminophen/Ibuprofen
- Scabies cream
- Topical Antibiotics:Bacitracin/Neosporin/Bactroban
- Topical Antipruritics:Calagel/Hydrocortisone/Benadryl

ALLERGIES AND DIET

ALLERGIES: ☐ No Known Allergies

☐ To foods **(list):**

☐ To Medications **(list):**

☐ To the environment, **(insect stings to include bees, hay fever, etc. list):**

☐ Other Allergies **(list):**

DIET:

☐ Eats a regular diet

☐ Has a medically prescribed meal plan or dietary restrictions **(list):**

PRESCRIPTION MEDICATIONS AND TREATMENTS: Please complete with Patient's current regimen for both scheduled and PRN medications to include peak flows, nebulizer treatments, blood draws/lab work, diabetic testing, insulin administration, dressing changes, via GT etc.; please use the back sheet for additional medications as need.

This person takes medication on a routine basis? YES/NO__________________

Name of Medication	Date Started	Reason for taking it	When is it given	Amount or dose given	How is it given
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time		

ANY LIMITATIONS ON ACTIVITY: YES / NO

Swimming __________ Hiking ____________ Athletics ____________ Canoeing ____________ Biking ____________Other____________ Explain:__________________________

I certify that I have on this date examined the above named and that on the basis of my examination and medical history as furnished to me, I have found no reason which would make it medically inadvisable for the kamper to participate in physically strenuous activities.

Physician's Signature ____Date__________________________ Date of Examination__________________________

Please Print: Physician's Name____License # ____

Address____Phone # ______________________________

Mail completed form to: Kamp Kiwanis, 9020 Kiwanis Rd, Taberg, NY 13471 or Fax to: (315) 336-3845 kampkiwanis@hotmail.com, www.kampkiwanis.org

Email missing pieces to: kampkiwanisapplications@gmail.com

Doctor: Please do not forget to provide to your patient with a current and up to date immunization record

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Additional Medications

Name of Medication	Date Started	Reason for taking it	When is it given	Amount or dose given	How is it given
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time		
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