

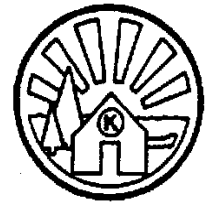
**2018 Kamp Kiwanis®**  
**Staff Health Exam by Health Care Professional**  
**Additional Medications**

Name of Medication	Date Started	Reason for taking it	When is it given	Amount or dose given	How is it given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time		
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# 2018 Kamp Kiwanis®

## Staff Health Exam by a Health Care Professional

**This form or a similar one must be completed to attend Kamp Kiwanis**



### 2018 MEDICAL EXAMINATION

Name \_\_\_\_\_ Age \_\_\_\_\_ 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): \_\_\_\_\_  
 Comments: \_\_\_\_\_

**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)  
 Chlorpheniramine maleate  
 Cough Suppressants  
 Decongestants (Sudafed & Sudafed PE)  
 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.

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**LIMITATIONS ON ACTIVITY:**  
 Swimming \_\_\_\_\_ Hiking \_\_\_\_\_ Athletics \_\_\_\_\_ Canoeing \_\_\_\_\_ 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 camper to participate in physically strenuous activities.

Health Care Professional's Signature \_\_\_\_\_ Date \_\_\_\_\_ Date of Examination \_\_\_\_\_

Please Print: Health Care Professional \_\_\_\_\_ License # \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_