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
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time		

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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)
Chlorpheneramine 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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			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time		

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 kamper to participate in physically strenuous activities.

Health Care Professional's Signature _____Date_____ Date of Examination_____

Please Print: Health Care Professional_____License # _____

Address_____Phone # _____

Mail completed form to: Kamp Kiwanis, 9020 Kiwanis Rd, Taberg, NY 13471 or Fax to: (315) 336-3845