2018 Kamp Kiwanis®
Health Exam by a Physician

IT IS INSUFFICIENT TO ATTACH YOUR OWN HEALTH RECORD, THIS FORM MUST BE COMPLETED IN FULL IN ORDER TO ATTEND KAMP KIWANIS
To be filled out by a Licensed Physician, Physician's Assistant or Nurse Practitioner representing the Licensed Physician
2018 MEDICAL EXAMINATION (DOCTOR TO COMPLETE):

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): _____

Physical Exam completed today? YES/NO_____ If NO Date of last Physical Exam:_____

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

Acetaminophen
Aloe
Antacids
Antihistamines
Aspirin
Auralgan (ear drops)
Calamine
Chloraseptic Throat Spray
Chlorphenermine Maleate
Cortaid
Cough suppressants
Dextromethorphan
Dimetapp
Guaifenesin (Robitussin any form)
Ibuprofen
Insect Repellent
Laxatives for Constipation
Lice Treatment
Pepto-Bismol
Scabies Cream
Sting Swabs
Sudafed & Sudafed PE
Sunburn Spray
Sunscreen
Topical Antibotic Cream
Topical Antipruritics

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 # _____

Upload or Mail completed form to: Kamp Kiwanis, 9020 Kiwanis Rd, Taberg, NY 13471 or Fax to: (315) 336-3845 kamp@kampkiwanis.org, www.kampkiwanis.org
Email missing pieces to: applications@kampkiwanis.org

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		
			☐Breakfast ☐Lunch ☐Dinner ☐Bedtime ☐Other time		
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