Medical / Immunization Form

TO BE COMPLETED BY EXAMINING PHYSICIAN

Camper's Name _____ **Weight** _____

Home Address _____ **City**_____ **State** ____ **Zip** ____ **Height** _____

Individualized Orders

Standard Over-the-Counter/PRN Medications (available in the infirmary/First Aid Kit) To be administered at the discretion of an RN unless otherwise indicated by you

DRUG (or generic equivalent)	**ROUTE**	**DOSAGE**	**SCHEDULE**	**CONTRA-INDICATED** Check only if Med. Is NOT to be given	**COMMENTS**
Tylenol	PO	Per label instructions by age/weight	q 6hr prn for discomfort or elevated temp		
Ibuprofen	PO	Per label instructions by age/weight	q 4hr prn for discomfort or elevated temp		
Robitussin	PO	Per label instructions by age/weight	q 4hr prn for cough		
PeptoBismol	PO	Per label instructions by age/weight	q 30 min to 1hr prn for diarrhea (not>8 doses /24hr)		
Mylanta	PO	Per label instructions by age/weight	TID-QID prn for gastric upset		
Dramamine	PO	Per label instructions by age/weight	½ hr before embarkation, then q 6-8hr pm for motion sickness		
Dimetapp	PO	Per label instructions by age/weight	q 6-8hr for nasal congestion/ drainage		
Benadryl	PO	Per label instructions by age/weight	q 6hr prn for allergic reaction		
Sudafed	PO	Per label instructions by age/weight	g 6-8hr for nasal congestion/ drainage		
Tums	PO	Per label instructions by age/weight	q 30 min prn for gastric upset/ heartburn		
NaphconA	Eye gtts	Per label instructions by age/weight	1-2gtts affected eye for itching/ burning		
Milk of Magnesia	PO	Per label instructions by age/weight	BID-TID pm for gastric upset/ constipation		
Ear Drops	TOP	Per label instructions by age/weight	As indicated		
Cortisone Ointment	TOP	Per label instructions by age/weight	As indicated		
Antifungal Ointment Spray	TOP	Per label instructions by age/weight	As indicated		

SPECIAL RESTRICTIONS:

Diet_____
Swimming_____
Strenuous Activity_____
Other_____

To the best of my knowledge the information stated above is true and accurate and it is my opinion that the camper listed above is physically able to engage in all camp activities, except as noted above.

Physician's Signature_____ **Date**_____

Physician's Name_____ **Phone**_____

Immunization History:

Please record month and year of basic immunizations and most recent booster. We do not have it on file from previous years.

Immunization	Date Basic Series Completed	Most Recent Booster
DPT or DT		
TETANUS		
ORAL POLIO		
MMR		
PPD/MANTOUX		
HEPATITIS A		
HEPATITIS B		
VARICELLA		

Allergies	✔	Comments
PENICILLIN		
SULFA		
CEPHALOSPORINS		
Other Medication		
Food Allergies List foods child is allergic to		
Bees/Insect Bites		

Has child ever had an anaphylactic reaction? ❒Yes
If yes, are you must send an EpiPen to avoid charges.
(Check expiration date)

Medical History

Indicate Date of Illness

Chicken Pox _____
Measles _____
German Measles _____
Mumps _____
Hepatitis _____
Pneumonia _____

Indicate if being treated for the following:

Diabetes __ Seizures __
Seasonal Allergy __ Rheumatic Fever __
Frequent Ear Infection __ Frequent Strep Throat __
Asthma __ (If child is being treated for asthma please send along the tubing for the nebulizer as well as all inhalers being used.) Make sure nurse is notified before camp begins.

❒Positive PPD Date _____ CXRay Date _____

List Dates & Desc. of Operations, Serious Injuries, Etc.

_____
_____
_____
_____

Chronic or Recurrent Illness & Suggested Treatment

_____
_____
_____
_____

Due to recent outbreaks of serious illnesses, Baiseinu can only accept campers & staff members who are fully up-to-date on their vaccinations.