CAMP ORAYSA PHYSICIAN EXAMINATION FORM

Please note that the examination must have taken place within the past year.

TO BE COMPLETED BY PARENT OR GUARDIAN

Last Name | First Name | Middle Name | **Sex** ☐ Female ☒ Male | **Date of Birth** *(Month/Day/Year)* __ __ / __ __ / __ __ __ __

Address | City/Borough | State | Zip Code

Over-the-Counter Medications

Please select "Yes" to ALLOW a medication to be administered if deemed necessary by our medical personnel and "No" for those that MAY NOT be administered even if deemed necessary by our medical personnel

Yes	No	Medication
☐	☐	Acetaminophen (Tylenol)
☐	☐	Antacid (Mylanta)
☐	☐	Bisacodyl (Dulcolax)
☐	☐	Bismuth Subsalicylate (Pepto-Bismol)
☐	☐	Calcium Carbonate (Tums)
☐	☐	Cetirizine (Zyrtec)
☐	☐	Cough Syrup (Robitussin)
☐	☐	Dimenhydrinate (Dramamine)
☐	☐	Diphenhydramine (Benadryl)
☐	☐	Fexofenadine (Allegra)
☐	☐	Guaifenesin (Mucinex)
☐	☐	Ibuprofen (Advil, Motrin)
☐	☐	Loperamide (Imodium)
☐	☐	Loratadine (Claritin)
☐	☐	Naproxen (Aleve)
☐	☐	Pseudoephedrine (Sudafed)
☐	☐	Ranitidine (Zantac)

TO BE COMPLETED BY HEALTH CARE PROVIDER

Dietary Restrictions
☐ None ______
☐ Yes *(list)* ______

Does the child/adolescent have a past or present medical history of the following?
☐ Asthma ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
If persistent, check all current medication(s): ☐ Inhaled corticosteroid ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

Allergies ☐ None ☐ Epi pen prescribed
☐ Drugs *(list)* ______
☐ Foods *(list)* ______
☐ Other *(list)* ______

Please explain all checked items on an addendum
☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Other *(specify)* ______

Medications
☐ None ☐ Yes *(please list below)*
______

PHYSICAL EXAMINATION

Height ______ cm (__ __ %ile)
Weight ______ kg (__ __ %ile)
BMI ______ kg/m2 (__ __ %ile)
Heart Rate ______ bpm
Blood Pressure ______ / ______ mmHg

General Appearance:

Nl	Abnl	
☐	☐	HEENT
☐	☐	Dental
☐	☐	Neck
☐	☐	Lymph nodes
☐	☐	Lungs
☐	☐	Cardiovascular
☐	☐	Abdomen
☐	☐	Genitourinary
☐	☐	Extremities
☐	☐	Skin
☐	☐	Neurological
☐	☐	Back/spine
☐	☐	Psychosocial Development
☐	☐	Language
☐	☐	Behavioral

Describe abnormalities *(if not enough space please include an addendum)*: ______

IMMUNIZATION DATES CIR Number of Child | | | | | | | | | |

Vaccine	Dates			
Hep B	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Rotavirus		__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
DTP/DTaP/DT		__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
		__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Hib	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
PCV	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Polio	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __

Vaccine	Dates		
Influenza	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
MMR	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Varicella	__ __ / __ __ / __ __	__ __ / __ __ / __ __	
Td	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Tdap __ __ / __ __ / __ __	Hep A	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Meningococcal	__ __ / __ __ / __ __	__ __ / __ __ / __ __	
HPV	__ __ / __ __ / __ __	__ __ / __ __ / __ __	__ __ / __ __ / __ __
Other *(specify)* ______	__ __ / __ __ / __ __;	______	__ __ / __ __ / __ __

IMPORTANT

If the patient will be continuing **any** medications in camp (including vitamin/herbal/PRN/over-the-counter) please attach a signed letter detailing the dosage, the time of day it should be taken, and why the patient is taking the medication. In addition, please make sure that there is an adequate supply for the duration of his stay in camp.

Please use this space to write anything else of importance:

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet
☐ Restrictions (*specify*) ______

Follow-up Needed ☐ No ☐ Yes, for ______
☐ Appt. date: __ __ / __ __ / __ __

ASSESSMENT ☐ **Well Child** ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**
______ __ __ __ __ __
______ __ __ __ __ __
______ __ __ __ __

Health Care Provider Signature | Date __ __ / __ __ / __ __

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

Stamp Here
Please make sure all information requested is completed

(For office use only) ☐ Follow Up ______ # Pgs ____
☐ Complete ☐ Ins ☐ Mening ☐ Persnl Info