STAFF PHYSICAL EXAMINATION FORM 2025

Speculator, NY 12164

This form is to be completed and signed by a Licensed Medical Provider. A physical is required within **one year** of the camper session.

Name:_____ **Date of Physical**:_____

DOB:_____ **B/P**:_____ **Weight**:_____ **Height**:_____

Additional Information for Health Care Staff:_____

_____

IMMUNIZATION HISTORY – attach a copy of immunizations. A legal waiver must be signed for conscientious exemption (NY State Immunization Exemption form can be filled out on the camper's profile online)

Medical History:

- ❒ No Health Concerns
- ❒ Anxiety
- ❒ Asthma
- ❒ ADHD, ADD
- ❒ Bone, Muscle Injury
- ❒ Depression
- ❒ Eating Disorder
- ❒ Seizure Disorder
- ❒ Sleep Problems
- ❒ Headaches/Migraines
- ❒ Head Injury/Concussion
- ❒ Diabetes (MD signature is required on a Diabetic Care Plan)
- ❒ Other:

Current Treatment:_____

Dietary Restrictions (all restrictions must be listed here in order to be supported by camp kitchen):

_____

Allergies – please describe reactions and management

❒ No Known Allergies

ALLERGEN	TYPE OF REACTION	TREATMENT
❒ Food:		
❒ Medication(s):		
❒ Insect Stings:		
❒ Other:		

In my opinion, this woman is fit for a very active wilderness camp, which includes, but is not limited to: hiking, water sport activities and navigating outdoor terrain on an island.

❒ Yes ❒ No

MEDICATION ADMINISTRATION AUTHORIZATION

New York State Law requires a physician's signature for any medication to be dispensed by the Camp Health Director. No medications will be given unless signed off by your physician.

New York State requires all prescription AND over-the-counter medications that are taken regularly by a camper to be listed on this form. This includes creams, supplements, vitamins, and essential oils.

DIAGNOSIS	MEDICATION	DOSAGE	FREQUENCY

OVER-THE-COUNTER MEDICATIONS The following non-prescription medications are stocked in the Camp Health Center and are given by the Health Director, on an as needed basis. Please **DO NOT** send any of the following to camp.

MEDICAL PERSONNEL ONLY: All of the following may be given unless otherwise noted. Please **verify with parents/guardians** if selecting "no" for any OTC medication.

MEDICATION	NO
Acetaminophen (Tylenol)	
Ibuprofen (Advil, Motrin)	
Cough Drops	
Diphenhydramine (Benadryl)	
Phenylepherine Decongestant (Sudafed PE)	
Guaifenisen (Tussin)	
Chloraseptic Throat Spray	
Vitamin C	
Dramamine	
Immodium AD	
Tums	
Pepto-Bismol	
Stool softener	
Muscle Rub (Bengay)	
Lotrimin	
Hydrocortisone Cream	
Visine	
Orajel	
Albuterol Inhalation Solution 0.083% via SVN	
Zyrtec	
Other:	

I have examined the patient herein described and have reviewed their health history.

Licensed Medical Provider Signature:_____**Date:**_____

Physician Name (print):_____**Phone Number:**_____

Address:_____