Participant name: _____

PARTICIPANT PHYSICAL EXAM

american CAMP association®

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health & Association of Camp Nurses

TO PARTICIPANT/PARENT(S)/GUARDIAN(S)/CARE PROVIDER(S): Please follow the instructions below. Attach additional information if needed. All information is kept confidential.

1) Take this form to the participant's healthcare provider.

2) The healthcare provider will complete the RECOMMENDATIONS FOR LICENSED MEDICAL PERSONNEL sections 1-12

4)After it has been completed & signed, return the form to camp via mail/fax/e-mail (see right) no later than two weeks prior to the start of the session.

easterseals Camp Fairlee

Address: 22242 Bay Shore Road

Chestertown, MD, 21620

Phone: (410) 778-0566

Fax: (410) 778-0567

E-mail: fairlee@esdel.org

PLEASE FOLLOW THESE INSTRUCTIONS CARFEULLY. ALL SECTIONS OF THE FORM MUST BE COMPLETED IN THEIR ENTIRETY. INCOMPLETE FORMS MAY NOT BE ACCEPTED AND WILL BE RETURNED WITH A REQUEST FOR ANY MISSING INFORMATION.

Recommendations for Licensed Medical Personnel

TO LICENSED MEDICAL PERSONNEL:

PLEASE TAKE THE TIME TO THOROUGHLY COMPLETE THIS INFORMATION SO THAT EASTERSEALS MAY PROVIDE THE BEST SERVICE AND APPROPRIATE CARE TO MEET THE NEEDS OF THE PARTICIPANT. ALL SECTIONS MUST BE COMPLETED.

Please sign the Physician Authorization (SECTION 12).

Attach additional information if needed. All information on this form is kept confidential.

SECTION 1: PARTICIPANT INFORMATION

Participant name: _____

☐ Male ☐ Female Birth date: _____ Age on arrival at camp: _____

Participant home address: _____

City: _____ State: _____ Zip code: _____

Participant name: _____

SECTION 2: PHYSICAL EXAM

Weight: _____ lbs. Height: _____ ft. _____ in. Blood pressure: _____ /_____

SECTION 3: DIAGNOSIS

The participant is undergoing treatment at this time for the following diagnosis/conditions: (please describe below)

SECTION 4: FOR THOSE WITH DOWN SYNDROME:

Individuals with Down Syndrome who wish to participate in the challenge course, horseback riding or similar activities, must complete this portion of the application :

Neurologic Symptoms of Atlantoaxial Instability: ☐ Present ☐ Absent X-ray Date: _____

Special Precautions/Needs: _____

SECTION 5: NON-PRESCRIPTION MEDICATIONS

The following non-prescription medications are listed on the camp's standing orders and stocked in the camp health center. They are used on an as needed basis to manage illness and injury. A physician's order is required by the Maryland Nursing Regulations. Please check those the participant may take while attending camp:

☐ Acetaminophen (Tylenol)	☐ Antihistamine/allergy medicine	☐ Lice shampoo (Nix, Elimite)
☐ Ibuprofen (Advil, Motrin)	☐ Diphenhydramine (Benadryl)	☐ Calamine Lotion
☐ Pseudoephedrine decongestant (Sudafed)	☐ Loratadine (Claritin)	☐ Hydrocortisone 1%
☐ Phenylephrine decongestant (Sudafed PE)	☐ Laxatives (Ex-Lax)	☐ Antibiotic Cream
☐ Guaifenesin cough syrup (Robitussin)	☐ Milk of Magnesia	☐ Aloe
☐ Dextromethorphan cough syrup (Robitussin DM)	☐ Antacid	☐ Sunscreen
☐ Generic cough drops	☐ Anti-diarrhea	☐ Bug Spray
☐ Sore throat spray	☐ Bismuth subsalicylate (Pepto-Bismol)	☐ Oxygen

Participant name: ____

SECTION 6: PRESCRIPTION MEDICATIONS

☐ No daily medications ☐ Will take the following medication(s) while at camp:

Please list all medications the participant is to receive at camp. 'Medication' is any substance a person takes to maintain and/or improve health. This includes vitamins & natural remedies. In order for camp to administer medication(s), please bring them in their original bottles or pharmacy-prepared blister packs with the original label attached. Camp cannot accept pre-poured medications. Provide enough (& one extra dose) of each medication to last the entire time the participant will be at camp.

Name of medication	Reason for taking it	When it is given	Amount or dose given	How it is 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: _______		

*****PLEASE COPY THIS PAGE IF MORE MEDICATIONS ARE TAKEN*****

Participant name: _____

SECTION 7: SEIZURES

Please complete this section if the participant is currently having seizures, or has a history of seizures.

Type: _____

Frequency: _____ Duration: _____

Triggers: _____

Date of last seizure: _____ Are the seizures currently under control? ☐ Yes ☐ No

SECTION 8: IMMUNIZATION HISTORY

Please provide the month and year for each immunization. Starred (★) immunizations must include the date to meet ACA standards. Copies of immunization records from healthcare providers or state or local government are acceptable. Please attach them

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis (DTaP/TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)						
Meningococcal meningitis (MCV4)						

Has the participant had chicken pox? ☐ Yes ☐ No If 'Yes,' date of chicken pox:_____

Has the participant had the COVID-19 Vaccine? ☐ Yes ☐ No Date of Second Dose: _____

Date of last tuberculosis (TB) test: _____ Result: ☐ Negative ☐ Positive

★ Date of last tetanus booster (dT or TdaP – **MUST PROVIDE**): _____

COVID Vaccine: ☐ Yes ☐ No 1st Dose: _____ 2nd Dose: _____ Booster: _____

SECTION 9: IMMUNIZATION RELEASE

If you are unable to provide sufficient/complete immunization records and/or the participant has not been fully immunized, please sign the following statement/release:

I UNDERSTAND AND ACCEPT THE RISKS TO THE PARTICIPANT FROM NOT BEING FULLY IMMUNIZED.

Signature: _____ Relationship: _____ Date: _____

Participant name: _____

SECTION 10: SPECIALIZED MEDICAL PROCEDURES/TREATMENTS

Will the participant require specialized medical procedures/treatments/therapies to be continued at camp? ☐ Yes ☐ No

(for example: tube feeding, nebulizer treatment, catheterization, insulin injection, etc.)

If 'Yes,' please describe the procedures/treatments/therapies and any precautions below:

SECTION 11: ADDITIONAL INFORMATION

Please provide in the space below any additional information about the participant's health that you think important, or that may affect their ability to fully participate in the camp program:

SECTION 12: PHYSICIAN AUTHORIZATION

I have examined the participant herein described and reviewed the. I have discussed the camp program with the participant and/or their parent(s)/guardian(s). It is my opinion that the participant is physically and emotionally fit to participate in an active camp program (except as noted.) I hereby authorize Easterseals' healthcare staff to perform the specialized medical procedures and distribute the medications listed as prescribed.

Name of licensed provider (please print): _____ Office phone: _____

Office address: _____

Signature: _____ Date: _____