

# Camp Paivika 2010

P.O. Box 3367  
 Crestline, CA 92325  
 (909) 338-1102

## MEDICAL EXAMINATION

**A LICENSED PHYSICIAN MUST COMPLETE THE MEDICAL EXAMINATION FORM. A MEDICAL EXAMINATION MUST BE PERFORMED WITHIN 12 MONTHS PRIOR TO CAMP ATTENDANCE.**

Camper Information				
NAME:	SEX:	AGE:	BIRTHDATE:	
DIAGNOSIS OR DISABILITY:				
BP:	Pulse:	Resp:	Does camper have a shunt? YES <input type="checkbox"/> NO <input type="checkbox"/>	Does camper have a Harrington Rod? YES <input type="checkbox"/> NO <input type="checkbox"/>
DOES CAMPER HAVE A HISTORY OF SEIZURES?			YES <input type="checkbox"/>	NO <input type="checkbox"/>
IF YES, SPECIFY TYPE:				
FREQUENCY:			LENGTH:	
PRESENT STATUS:			DATE OF LAST SEIZURE:	
NOTE: RE: SEIZURE MEDICATION (S): <b>It is preferred that no seizure medication changes be made within 30 days prior to camp arrival.</b>				

DATE OF TB TEST: \_\_\_\_\_ TB TEST RESULT: \_\_\_\_\_

## MEDICAL AUTHORIZATION FOR ACTIVITY PARTICIPATION

**ALL ACTIVITIES ARE NON-COMPETITIVE AND CAREFULLY SUPERVISED. THEY ARE DESIGNED FOR INDIVIDUALS WITH PHYSICAL RESTRICTIONS AND DEVELOPMENTAL DELAYS. CAMP STAFF WILL STRICTLY OBSERVE PHYSICIAN RECOMMENDATIONS.**

Please indicate activities in which camper may participate and any necessary restrictions:

1. Attend Camp Paivika which is at an altitude of 5,365 feet? YES \_\_\_\_\_ NO \_\_\_\_\_
2. The camp pool is heated up to 90°. May the camper participate in pool activities?  
YES \_\_\_\_\_ NO \_\_\_\_\_
3. May the camper participate in horseback riding? YES \_\_\_\_\_ NO \_\_\_\_\_  
*Campers are supported by side-walkers but **must be able to sit on horse independently***
4. Are there any other precautions/restrictions you would like the camper to observe while at camp?:  
**IF YES, please specify:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**X** \_\_\_\_\_  
 Signature of Physician Date

CAMPER NAME: \_\_\_\_\_

**MEDICATIONS TO BE ADMINISTERED AT CAMP:**

If the camper is taking any prescription medications, herbal/homeopathic medications, vitamins/minerals, aspirin, or other over-the-counter medications, **they must** be listed on the attached MEDICATION RECORD or they will not be given at camp.

If additional MEDICATION RECORD sheets are necessary, please make copies of the enclosed form. Please note that each individually listed medication must be signed off by the physician.

**All medications must be consistent with what is listed on the MEDICATION RECORD at the time of camp attendance or a new, signed form by the camper's physician will be required.**

TREATMENTS TO BE CONTINUED AT CAMP: \_\_\_\_\_

\_\_\_\_\_

**OVER THE COUNTER MEDICATIONS:**

Nurses at camp follow standing orders from our physician consultant, which include over-the-counter medications as needed, such as analgesics, topical ointments, decongestants, and medications for colds, allergies, indigestion, constipation, diarrhea, eye and mouth care, and basic first aid.

Are there any concerns with administration of over-the-counter medications and/or treatments? YES ( ) NO ( )

IF YES, EXPLAIN AND/OR LIST MEDICATIONS **NOT** TO BE GIVEN: \_\_\_\_\_

\_\_\_\_\_

**HEALTH STATEMENT**

I hereby certify that the above camper is in good health and physically able to attend camp at an altitude of 5,365 feet. The camper has no evidence of a skin rash or communicable ailment that might endanger the health of other people. The camper has had no recent illnesses with the exception of: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Physician <b>X</b>	Date of exam	Date of form completion	
Name of Physician		Physician's address	
Name of medical agency if camper attends a clinic or hospital		Telephone No.	Fax No.

Your PHYSICIAN MUST sign after each listed medication.

Date \_\_\_\_\_ Camper  
Name: \_\_\_\_\_

Physician's Name (print legibly): \_\_\_\_\_ Phone  
No. \_\_\_\_\_

PHYSICIAN PLEASE COMPLETE THIS SECTION		FOR CAMP USE ONLY							
Name of Medication and Dosage	Times to administer medication	Dates and Initials of Nurse administering Medication.							
<b>Rx:</b>  <b>Dosage:</b>  <b>Physician's Signature:</b> _____	Breakfast								
	Lunch								
	Dinner								
	Bedtime								
<b>Rx:</b>  <b>Dosage:</b>  <b>Physician's Signature:</b> _____	Breakfast								
	Lunch								
	Dinner								
	Bedtime								
<b>Rx:</b>  <b>Dosage:</b>  <b>Physician's Signature:</b> _____	Breakfast								
	Lunch								
	Dinner								
	Bedtime								
<b>Rx:</b>  <b>Dosage:</b>  <b>Physician's Signature:</b> _____	Breakfast								
	Lunch								
	Dinner								
	Bedtime								

Camp Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Camp Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CAMPER NAME:** \_\_\_\_\_

PHYSICIAN PLEASE COMPLETE THIS SECTION		FOR CAMP USE ONLY							
Name of Medication and Dosage	Times to administer medication	Dates and Initials of Nurse administering Medication.							
<b>Rx:</b>  <b>Dosage:</b>  <b>Physician's Signature:</b> _____	Breakfast								
	Lunch								
	Dinner								
	Bedtime								
<b>Rx:</b>  <b>Dosage:</b>  <b>Physician's Signature:</b> _____	Breakfast								
	Lunch								
	Dinner								
	Bedtime								
<b>Rx:</b>  <b>Dosage:</b>  <b>Physician's Signature:</b> _____	Breakfast								
	Lunch								
	Dinner								
	Bedtime								
<b>Rx:</b>  <b>Dosage:</b>  <b>Physician's Signature:</b> _____	Breakfast								
	Lunch								
	Dinner								
	Bedtime								

Camp Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Camp Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_