LIONS CAMP HORIZON
PHYSICAL EXAMINATION FORM

THIS FORM MUST BE RECEIVED NO LATER THAN JUNE 1st

PART I: Personal Information (to be completed by parent/guardian)

Camper's Name: ____________________________________ Nickname:________________________ DOB:____________
_____ Male _____ Female Custodial Parent/Guardian:____
Address: ____
Street City State Zip
Telephone: _____________________________ Email Address: ____

PART II Medical Information (to be completed by healthcare provider)
Height:_______ Weight:_______ Blood Pressure:_______ Heart Rate:_______ Respiration:_______ Temp:_______

Assessment:
Skin/scalp: __________ Eyes: __________ Ears: __________ Nose, throat, & mouth: __________ Glands: __________
Teeth & gums: ___________ Lungs: ___________ Heart: ___________ Abdomen: ___________
Allergies:
Medications: ____
Insect stings:__________________________________ Does camper have a prescription for an Epi-Pen? ______________
Environmental: ______________________________ Other: ____
Does camper have a prescription for a rescue inhaler? Yes _____ No _____
Does camper have a history of seizures? Yes _____ No _____ Date of last seizure:_________ If yes, please advise what type and frequency: ____
____
Does camper require a portable oxygen tank?_________________________ CPAP or VPAP:________________________
Does camper require a mouth guard during sleep?____

Vaccinations:
Date of last Tetanus vaccine: ________ Date of last TB test: ________ Positive: _____ Negative: _____ PPB reactor: _____
Date of COVID-19 vaccination: ____

Current or chronic medical conditions: ____
____
____
____

Medically prescribed dietary restrictions or meal plan: ____
____
____
____

Camp activities include nature walks, outdoor games and activities, arts & crafts and bowling. Please advise any restrictions on physical activities at camp: ____
____
____

Additional information for our nursing staff: ____
____
____
____
____

Rev. 02/07/2021

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MEDICATIONS

No prescription medications or over-the-counter medications will be dispensed to the camper without the signature of a licensed healthcare provider. Please provide a complete list of the medications prescribed for this camper including herbal remedies in the box below. Unless medically necessary to do otherwise, medications are administered at the following times: 8AM (breakfast), Noon (lunch), 5PM (dinner), and 8PM. Please write exceptions to this under “Comments.”

PRESCRIPTION MEDICATIONS

Medication	Dosage	Comments

OVER - THE - COUNTER MEDICATIONS

I authorize the use of the following OTC medications to be used for their intended purposes on a PRN (as needed) basis for a maximum of two consecutive days. A check has been placed before each of the medications that may be administered.

_____ Acetaminophen 325mg 1-2 tabs or liquid equivalent, for headache, pain, menstrual cramps or fever >100.5
_____ Ibuprofen, 200mg 1-2 tabs, or liquid equivalent, for headache, pain, or menstrual cramps or fever >100.5
_____ Diphenhydramine 25mg, 1-2 tabs, or liquid equivalent for itching, rash or allergic reaction
_____ Non-narcotic cough suppressant/expectorant 2 tsp (10cc) for cough _____ Sugar free only
_____ Cough drops 1 lozenge, for sore throat (up to 10 drops per day)
_____ Pseudoephedrine HCL 30mg 2 tabs, for nasal congestion due to colds or sinusitis
_____ Alum/Magnesium Hydroxide liquid w/ simethacone 2 tbsp (30cc)
_____ Pepto Bismol 2 tbsp (30cc) _____ Simethicone 1-2 tabs after meals for gas (not to exceed 4 tabs per day)
_____ Milk of Magnesia 2 tbsp (30cc) followed by 8 ounces of water for constipation
_____ Kaopectate 2 tbsp (30cc) for diarrhea. One dose after each loose bowel movement for a maximum of 8 tbsp/24 hours
_____ Loperamide HCL liquid 4 tsps (20cc) for first loose bowel movement and 2 tsps (10cc) after each other loose bowel movements for a maximum of 8 tsps (40cc) in a 24 hour period
_____ Visine eye drops or similar product 1-2 drops per eye for red, itchy eyes
_____ Bacitracin for minor abrasions _____ Triple Antibiotic Cream for minor abrasions
_____ Hydrogen Peroxide full strength for cleaning minor cuts and abrasions of the skin
_____ Betadine Solution full strength for wound disinfection, abrasions, emergency lacerations
_____ Dermoplast (spray) TID, for relief of minor burn discomfort _____ Blistex or _____ Vaseline for chapped lips
_____ Sunscreen SPF 30 or higher and/or _____ Insect Repellant (neither subjected to the two day limit)

Signature of licensed practitioner completing Health Exam Form: ______________________________

Printed name: ______________________________ Date: ______________

Telephone number: ______________________