

# CRC – Irish Dance Camp Physical Examination Form 2024

(As mandated by the State Health Depts.)



**ALL CATEGORIES (FRONT & BACK) MUST BE ADDRESSED AND COMPLETED**

Camper Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Gender \_\_\_\_\_ Examined By \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE ATTACH A COPY OF IMMUNIZATION RECORD TO THIS FORM**

Height:	
Weight:	
BP:	

<b>Allergies:</b>	
1. Drugs:	
2. Environmental:	
3. Food:	

Dietary Requirements:

**MEDICAL HISTORY**  
(check all that apply)

- ADD/ADHD
- ANAPHYLAXIS
- ASTHMA-EIA
- CARDIAC DISEASE
- DIABETES
- EATING DISORDER
- EMOTIONAL DISORDER/ANXIETY
- ENURESIS
- FAINTING
- FRACTURES
- HAYFEVER
- HEADACHES
- MIGRAINES
- SCOLIOSIS
- SEIZURE DISORDER
- SHIN SPLINTS
- SPRAINS
- THYROID DISORDER
- VISUAL DISORDER
- OTHER

~ Pertaining to above MEDICAL HISTORY, please clarify and identify special needs while attending camp (use separate sheet if necessary)

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~ Does Camper have any significant or recent fracture, sprain or orthopedic condition?

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~ Does camper require the use of any orthopedic device, brace or bandage? If yes, please clarify (be sure to bring devices with you to camp)

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~ Is camper able to participate in a very strenuous dance program and other active sports and camp activities?    Yes                  No

If no explain:

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**ALL CATEGORIES PERTAINING TO MEDICATIONS MUST BE COMPLETED BY PHYSICIAN/PA**

**Prescription Medications:** if none check here

Complete the following according to camper's current regimen. Use separate sheet if necessary

DRUG NAME	DOSE/ROUTE	INTERVAL	REASON

**OTC – Stock Medications:**

*Camp Rince Ceol stocks all medications listed below. Unless otherwise indicated by the camper's physician or PA in the comment column below, PRN medications and Topical Medications may be administered at the discretion of the Camp Nurse according to complaint, age and weight.*

<i>PRN Medications</i>	<i>Comment</i>
<b>ACETAMINOPHEN:</b> Tabs	
Chewable tabs	
Elixir	
<b>IBUPROFEN:</b> Tabs	
Chewable tabs	
Suspension	
<b>CALCIUM CARBONATE</b> (regular strength):	
Chewable tabs	
<b>COUGH DROPS</b>	
<b>DIPHENHYDRAMINE HCL:</b> Tabs	
Elixir/syrup	
<b>GUAIFENESIN</b> (expectorant):	
Solution	
<b>SIMETHICONE:</b> Chewable tabs	
<b>MELATONIN:</b> Tabs	
Chewable/dissolvable	
<b>MULTI-VITAMIN:</b>	
<b>CLARITAN/ZYRTEC:</b>	
<b>FLONASE:</b>	
<b>ANTI-HISTAMINE:</b> Loratadine (Claritin)	
Cetirizine Hydrochloride (Zyrtec)	
Fexofenadine (Allegra)	
<b>SINGULAIR:</b>	
<b>LACTAID:</b>	
<b>NAPROXEN:</b>	
<b>MUCINEX:</b>	
<b>OMEPREZAL:</b>	

<i>Topical Medications</i>	<i>Comment</i>
<b>ANALGESIC HEAT RUB</b>	
<b>ANTIBIOTIC CREAM</b>	
<b>ANTI-ITCH CREAM</b>	
<b>CALAMINE LOTION</b>	
<b>CORTISONE CREAM</b>	
<b>EYE WASH</b>	
<b>INSECT REPELLENT</b>	
<b>SUNSCREEN</b>	

**MEDICAL STATEMENT & RELEASE**

The above named Camper has been examined and on the basis of my findings, as indicated on the Health Form and my knowledge of the applicant, I find that he/she *is able to participate in an active camp program*. I have reviewed and completed the **medication portion** of this form (Prescription, PRN's and Topical)

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Telephone # \_\_\_\_\_

Stamp
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