CRC – Irish Dance Camp

Physical Examination Form 2027

(As mandated by the State Health Depts.)

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

Camper Name _____ **DOB**_____ **Age**_____

Gender _____ **Examined By**_____**Date of Last Exam**_____

PLEASE ATTACH A COPY OF IMMUNIZATION RECORD TO THIS FORM

Height:	
Weight:	
BP:	

Allergies:	
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)

_____

_____

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

_____

_____

~ 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)

_____

_____

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

_____

This Authorization Form Must Be On File For CAMPER NAME: _____

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

Prescription and Non-Prescription Medications Camper is taking while at Camp: 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.

PRN Medications	*Comment*
ACETAMINOPHEN: Tabs	
Chewable tabs	
Elixir	
IBUPROFEN: Tabs	
Chewable tabs	
Suspension	
CALCIUM CARBONATE (regular strength):	
Chewable tabs	
COUGH DROPS	
DIPHENHYDRAMINE HCL: Tabs	
Elixir/syrup	
GUAIFENESIN (expectorant):	
Solution	
SIMETHICONE: Chewable tabs	
~~**CLARITAN/ZYRTEC:**~~	
FLONASE:	
ANTIHISTAMINE: Loratadine (Claritin)	
Cetirizine Hydrochloride (Zyrtec)	
Fexofenadine (Allegra)	
~~**NAPROXEN:**~~	
~~**MUCINEX:**~~	
OMEPREZAL:	

Topical Medications	*Comment*
ANALGESIC HEAT RUB	
ANTIBIOTIC CREAM	
ANTI-ITCH CREAM	
CALAMINE LOTION	
CORTISONE CREAM	
EYE WASH	
INSECT REPELLENT	
SUNSCREEN	

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