

2010 Kamp Kiwanis®

Health Exam by a Physician



IT IS INSUFFICIENT TO ATTACH YOUR OWN HEALTH RECORD, THIS FORM MUST BE COMPLETED IN FULL IN ORDER TO ATTEND KAMP KIWANIS
 To be filled out by a Licensed Physician, Physician's Assistant or Nurse Practitioner representing the Licensed Physician
 2010 MEDICAL EXAMINATION (DOCTOR TO COMPLETE):

Name _____ Age _____ Height _____ Weight _____

BP _____ P _____ Vision R20/ _____ L20/ _____ Ears _____ Throat _____ Teeth _____ Skin _____

Respiratory _____ Cardiovascular _____ Musculoskeletal _____ Neurological _____

Liver _____ Spleen _____ Genitalia _____ Hernia _____ U/A _____ Asthma _____

The patient is under the care of a physician for the following condition(s): _____

Comments: _____

INDIVIDUALIZED ORDERS: The following non-prescription medications are commonly stocked in the Kamp Health Center and are used on an as needed basis to manage illness and injury.
Medical personnel: Cross out those items the camper should not be given.

Aloe
 Antacids
 Auralgan (Ear Drops)
 Bismuth Subsalicylate (Pepto-Bismol)
 Calamine Lotion
 Chloraseptic (Sore throat spray)
 Chlorpheniramine maleate
 Cough Suppressants
 Decongestants (Sudafed & Sudafed PE)
 Diphenhydramine (Benadryl)
 Guaifenesin (Robitussin any form)
 Laxatives for constipation
 Lice shampoo
 Pain reliever/fever reducer: Acetaminophen/Ibuprofen
 Scabies cream
 Topical Antibiotics: Bacitracin/Neosporin/Bactroban
 Topical Antipruritics: Calagel/Hydrocortisone/Benadryl

ALLERGIES AND DIET

ALLERGIES: No Known Allergies

To foods (**list**):

To Medications (**list**):

To the environment, (**insect stings to include bees, hay fever, etc. list**):

Other Allergies (**list**):

DIET:

Eats a regular diet

Has a medically prescribed meal plan or dietary restrictions (**list**):

PRESCRIPTION MEDICATIONS AND TREATMENTS: Please complete with Patient's current regimen for both scheduled and PRN medications to include peak flows, nebulizer treatments, blood draws/lab work, diabetic testing, insulin administration, dressing changes, via GT etc.; please use the back sheet for additional medications as need.

Name of Medication	Date Started	Reason for taking it	When is it given	Amount or dose given	How is it given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time		

ANY LIMITATIONS ON ACTIVITY: YES / NO
 Swimming _____ Hiking _____ Athletics _____ Canoeing _____ Other: _____ Explain: _____

I certify that I have on this date examined the above named and that on the basis of my examination and medical history as furnished to me, I have found no reason which would make it medically inadvisable for the camper to participate in physically strenuous activities.

Physician's Signature _____ Date _____ Date of Examination _____
 Please Print: Physician's Name _____ License # _____
 Address _____ Phone # _____

Mail completed form to: Kamp Kiwanis, 9020 Kiwanis Rd, Taberg, NY 13471 or Fax to: (315) 336-3845

Doctor: Please do not forget to provide to your patient with a current and up to date immunization record

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Additional Medications**

Name of Medication	Date Started	Reason for taking it	When is it given	Amount or dose given	How is it given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time		
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