Physical Examination by Licensed Medical Professional (MD, DO, ARNP, PA)

The section below must be completed **in full** by a **licensed medical professional** who has conducted a physical examination of the individual anytime within 12 months before he or she arrives at Camp Thunderbird. Parent/Guardian may not pre-populate any blanks on this form. *Professionals, please complete legibly. Unreadable forms will not be considered complete and will be returned to you for clarification*. Guests will not be permitted without fully completed forms.

I examined (full legal name of guest) _____ on (exam date) _____.

Height _____ Weight _____ Blood Pressure _____

Body Temperature _____ Heart Rate _____ Respiratory Rate _____

The applicant is under the care of a physician for the following (must state all medical diagnoses treated)

_____

Restrictions/Recommendations while at camp (if none, state "no restrictions")_____

_____

Medications:

Please review the medication list form on the following page.

The following non-prescription medications and treatments are used by the Camp Thunderbird nursing staff on an as-needed basis. Please (X) any items the guest SHOULD NOT BE GIVEN while at camp.

Known allergies? (If none, state "no allergies") _____

Pain Management/Fever

- ☐ Acetaminophen (Tylenol)
- ☐ Ibuprofen (Advil)

Stomach Ache/Bowel Management

- ☐ Bismuth subsalicylate (Pepto)
- ☐ Milk of Magnesia

Cold/Sinus/Allergies

- ☐ Dextromethorphan
- ☐ Phenylephrine (Sudafed PE)
- ☐ Guaifenesin
- ☐ Diphenhydramine (Benadryl)
- ☐ Cough Drops

Topical

- ☐ Calamine lotion
- ☐ Hydrocortisone 1% cream
- ☐ Topical Antibiotic cream
- ☐ Aloe

Additional Information _____

_____

I have reviewed the health history form and medication list in its entirety and have conducted a physical examination. In my opinion, the applicant is able to participate in an active special needs camp program (except as noted).

Licensed Medical Professional Signature _____ Date _____

Printed Name _____ Title _____

Office stamp required.

Office Phone _____

Office Fax _____

I have understood the licensed medical personnel's recommendations and restrictions (if any) for the guest.

Guest/Guardian Signature _____ Date _____

Guest name _____

Guests from group homes may omit this page in lieu of a pharmacy generated MAR

Parent/guardian: Please complete the list below with all medications that are regularly taken by the guest. If any medications should change, a new list should be signed by a physician and provided to camp no less than 10 days prior to session.

Physicians: Please review the list and sign below. Please ensure that any attached pages are signed if applicable.

I have reviewed the medication list and confirm that this list includes all prescription medications that should be administered to the guest at camp.

Licensed medical professional signature: _____

Medication List

Medication Administration Information

Medications are dispensed at the following times: B—breakfast (8:00AM), L—lunch (1:00PM), S—snack (3:30PM), D—dinner (6:00PM), and HS—hours of sleep (8:00PM). Please attach an additional page if necessary.

Medication Name/Strength	Dose/# of Pills	Time Given	Reason for Taking
Ex. Aspirin, 81mg	1 tablet	B	General/heart health