The Rochester Rotary Sunshine Camp

Last Name _____ **First Name**_____ **Middle** _____**Nickname** _____

PART 2: PHYSICIAN FORM: ***This page must be completed by the applicant's physician***

CAN BE FAXED TO 585-546-8675

The Rochester Rotary Sunshine Camp **is designed to meet the needs of youth who are** *physically, emotionally or mentally challenged or have a chronic illness* **that would make it difficult or impossible for them to attend most other camps. Please review and fill out both sides of this form for the applicant under your care.** Those responsible for selection of eligible campers do not, as a rule, see the campers until after their arrival at camp. It is exceedingly important therefore, that you answer all the following questions completely and candidly and legibly.

Date of Birth _____/_____/_____ Approximate mental age of camper_____ Height _____ Weight _____

Copy of last Physical Exam (must be within the last 2 years) _____

DIAGNOSIS or **DIAGNOSES** of physical disability or chronic illness on which referral is made

_____

Descriptive statement of disability that will aid in the camp staff's understanding of the camper

_____

Other physical, mental, or emotional problems or diseases of which the nurse should be aware

_____

_____

Does the Camper have or has have seizures? If yes please state typical seizure activity

_____

REQUIRED IMMUNIZATIONS OR ATTACH A COPY	**Dates (of first series)**				**Dates of Boosters**		
	1st	**2nd**	**3rd**	**4th**	**1st**	**2nd**	**3rd**
D.P.T. (Diptheria-Whooping Cough-Tetanus)							
Tetanus-Adult							
Chicken Pox: Disease or Immunization? 2							
Hepatitis B Series				*OR* Titer:			
Polio (type: oral or injection)							
M.M.R. (Measles-Mumps-Rubella)			*OR* Rubella Titer:				
PPD (Most Recent)							
HIB (Haemophilus Influenza type B) 4							
Hepatitis A 2							
Menactra 1							

RESTRICTIONS: With Camp assuming the responsibility for supervision, are there any medical restrictions on using the pool or participating in sports?

_____

Is the camper a hepatitis carrier? _____ If so, what type? _____

Are there **any ALLERGIES** we should know about (Drug or Food)? _____

_____

The Rochester Rotary Sunshine Camp

Last Name _____ **First Name**_____ **Middle** _____

Note: If camper needs an epi pen, please write order in medicine section below.

MEDICINE: To be brought to camp by the camper in **original** container; the camp nurse will take charge of it. *If more space is needed please attach additional sheet.* **Please print legibly. If no medications taken, please write "none".**

Medication Name	Strength	Dosage/Route	Time When Given

Please indicate how medication is given (i.e., in applesauce) _____

The following Over the Counter medication or generic equivalent is available in the Sunshine Campus Infirmary. Parent and Doctor must indicate which medications may be administered by the camp nurse. Only medications that are circled "YES" and determined to be necessary will be administered at the discretion of a Registered Nurse. Administration will be "per label direction" unless otherwise specified by your physician.

Drug Name	Provider Order	Physician's Comments
Tylenol (discomfort/fever)	YES or NO	
Advil (discomfort/fever)	YES or NO	
Throat Lozenges (throat irritation, cough)	YES or NO	
Benadry (allergies)	YES or NO	
Claritan (allergies)	YES or NO	
Zyrtec (allergies)	YES or NO	
Chloraseptic Spray (throat irritation)	YES or NO	
Cortizone Cream (topical) for skin irritation	YES or NO	
Saline eye drops/wash	YES or NO	
Milk of Magnesia (constipation)	YES or NO	
Pepto Bismol/Kaopectate (stomach upset)	YES or NO	
Tums (heartburn/stomach upset)	YES or NO	
First Aid Cream/Neosporin (topical-cuts and scrapes)	YES or NO	
Lotrimin	YES or NO	
Sunscreen	YES or NO	
Orajel	YES or NO	
Calamine Lotion	YES or NO	
Insect Spray	YES or NO	

NOTE: If there is any change in routine or in medication subsequent to the filling out of this form, the Camp must receive **WRITTEN NOTIFICATION FROM THE PHYSICIAN.**

REQUIRED: Do you recommend this camper for the camp program in the belief that he/she will benefit from the experience and will not endanger or be endangered by the congregate life and activity of the group? YES ___ NO ___

Date____/____/____ Print Name_____ **Signed: _____, M.D.**

Office Address_____ Phone #_____

Office Fax #_____ Preferred Hospital? _____

If a clinic -- for whom should we ask when calling about this camper? _____

Address: _____Phone: _____

We greatly appreciate your cooperation in helping us select individuals who are able to participate in the activities of our summer overnight camping experience. **Return Physician Statement to parent or 180 Linden Oaks Suite 200, Rochester, NY 14625 FAX # 585-546-8675**