The Rochester Rotary Sunshine Camp

PHYSICIAN FORM

CAN BE FAXED TO 585-546-8675

Last Name _____ First Name_____ Middle _____Nickname _____

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

Date of last Physical Exam (must be within the last 2 years) – PLEASE ATTACH A COPY

DIAGNOSIS or **DIAGNOSES**

_____

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: 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** (Drug or Food)? _____

_____

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Last Name _____ First Name_____ Middle _____

MEDICINE: Please print legibly or attached 2018 medication list.

Medication Name	Strength	Dosage/Route	Time When Given

The following Over the Counter medication or generic equivalent is available in the Sunshine Campus Infirmary. Determined to be necessary will be administered at the discretion of a Registered Only medications that are circled "YES" and Nurse. Administration will be "per label direction" unless otherwise specified.

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	

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

Office Address_____ Phone #_____

Office Fax #_____ Preferred Hospital? _____

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 180 Linden Oaks Suite 200, Rochester, NY 14625 FAX # 585-546-8675**