The Rochester Rotary Sunshine Camp
PHYSICIAN FORM

Last Name _____ First Name_____ Middle _____Nickname _____

Date of Birth _____/_____/_____

Please ATTACH a copy of immunizations and physical exam

DIAGNOSIS or **DIAGNOSES**

_____

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

_____

_____

Does the Camper have or has have seizures? ____Yes ____No **If yes what type?**_____

RESTRICTIONS: Are there any restrictions on using the pool or participating in sports? ____Yes ____No
If yes please describe_____

Is the camper a hepatitis carrier? ____Yes ____ No **If yes what type?**_____

Food or drug allergies? ____Yes ____No
If yes please describe_____

The following over the counter medication or generic equivalent is available in the Sunshine Campus Infirmary. If determined to be necessary will be administered at the discretion of the medical staff. The medications will be administered "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	
Claritin (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	
Tums (heartburn/stomach upset)	YES or NO	
First Aid Cream/Neosporin (topical-cuts and scrapes)	YES or NO	
Lotrimin	YES or NO	
Calamine Lotion	YES or NO	
Miralax	YES or NO	

The Rochester Rotary Sunshine Camp

Fax Number 533-1810

Last Name _____ First Name_____ Middle _____

Please print legibly or attached 2018 medication list.

Medication and Strength	Dose	Route	Time to be given

PLEASE REVIEW MEDICATIONS WITH YOUR CHILDS PROVIDER AND SIGN BELOW- THIS MUST BE SIGNED BY BOTH THE PARENT/GUARDIAN AND MEDIAL PROVIDER PRIOR TO YOUR CHECK IN. INACCURATE INFORMATON WILL DELAY YOUR CHECK IN.

Parent Signature_____Date____/____/____

Medical Provider Signature_____ Date____/____/____

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 809 Five Points Rd, Rush, NY 14543 FAX # 585-533-1810**