**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** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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 |  |
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**Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_**

**Please print legibly or attached 2020 medication list.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication and Strength** | **Dose** | **Route** | **Time to be given** |
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***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**