PHYSICAL EXAMINATION & HEALTH HISTORY

This Physical Examination form must be completed and signed by a Licensed Physician.

We request this form to be completed no more than 1 year from your camp date to participate in camp.

Please bring along a copy of the camper's insurance card at time of check-in at camp

Please mail the completed form to:

Nicole Hart, Camp ROCK Nurse 15616 Boulder Creek Drive, Minnetonka, MN 55345

Camper's Legal Name:	DOB:	
Camper's Preferred Name:	Age (as of today):	Sex:
Address:	Pronouns:	
Primary Phone Number:	Secondary Phone Number:	

EXAMINATION COMPLETED BY DOCTOR

Diagnoses: Is any condition present, which may result in an emergency? Please describe:	
Allergies:	
Does this person carry an Epi-pen? YES / NO	Does this person carry an inhaler? YES / NO

Height: Weight:	Lungs:
Pulse: BP: / Temp:	Cardiac:
Head/Scalp:	Upper Extremities:
Eyes:	Lower Extremities/Edema/Circulation:
Vision:	Back/Spine:
Ears/Hearing:	Skin:
Mouth/Throat/Nose:	Nervous System/Pupil Reaction/Reflexes/Gait/Sensations:
Neck/Thyroid & Lymph Sys:	
Abdomen:	Free from communicable disease: YES / NO

PREVIOUS ILLNESS (give age when these occurred): Chicken Pox ___ Measles___ Mumps___ Scarlet Fever___ Other___

IMMUNIZATION HISTORY: Please give dates (month/year) of immunizations and most recent booster dates:
Date of last booster: DPT_____ ___ MMR__ _____ _____Tetanus _____ (update if not current)
COVID-19: 1st Dose_____ 2nd Dose_____Booster (if applicable)_____

All Vaccinations are up to date ___ Yes ____ No
If no please explain reason: _____

Camper: _____ DOB:___ /___/____

ACTIVITY RESTRICTIONS:

List any conditions, operations or known serious injury that may impact camp participation:	
Are there medical reasons to limit or restrict this individual from participating in the swimming program?	Yes/ No If yes, please Explain:
Please list any other activity restrictions while individual is participating in camp:	

MEDICATIONS:

Please complete with camper's current regimen for both scheduled and PRN medications. **No medication/vitamin/supplement can be administered at camp unless listed on the next two pages and signed by a licensed medical professional- no exceptions.**

Is this camper on medication (Including OTC and Vitamins)? ____ No ____ Yes, current medication list attached or listed below

Medication Name	Dose	Frequency	Indication	Special Instructions

Camper: _____ DOB:___ /___/____

INDIVIDUALIZED STANDING ORDERS

This Standard Order form must be completed and signed by a Licensed Physician.

Over the Counter Medications (Camp stock medications) For each medication listed below, CROSS OUT any medication that you, the camper's medical provider, do not permit be given at camp. All medications are gluten-free and will be given according to manufacturer's dosing instructions.

Medication Name	**Route**	**Schedule and Indications**
Diphenhydramine	Tab/Liquid/Chew	Q4-6 hours for mild to moderate allergic reaction
Ibuprofen	Tab/Liquid/Chew	Q4-6 hours for pain or fever
Acetaminophen	Tab/Liquid/Chew	Q6 hours for pain or fever
Loratidine	Tab	Q 24 hours for Allergies
Docusate Sodium	Softgel	PRN Constipation
Orajel	Ointment	PRN Tooth/Gum pain
Sore Throat Pops/Cough drops	Oral Demuclent	PRN Throat pain/irritation
Mucinex	Liquid	PRN Cough/mucus
Tussin DM	Liquid	PRN Cough
Tums	Chew	PRN Heartburn, upset stomach
Pepcid	Tabs	PRN Heartburn, upset stomach
Mylicon	Tabs	PRN Heartburn, upset stomach
Hydrocortisone	Topical	PRN Skin itching, irritation, bug bites, rash
Ivarest	Topical	PRN Skin itching, irritation, bug bites, rash
Dermoplast	Topical	PRN Skin itching, irritation, bug bites, rash
Caladryl Clear	Topical	PRN Skin itching, irritation, bug bites, rash
Triple Antibiotic	Topical	PRN Superficial cuts/wounds
Aloe Vera	Topical	PRN Sunburn
Sunscreen	Topical	PRN Sunburn protection
Swim Ear	Ear Drop	PRN Ear pain due to water in ear

By signing below, I, the camper's physician, certify that the information provided is accurate to the best of my knowledge.

Physician's Signature: _____

Physician Name (Please Print)	Date:
Address:	Phone: