



73 East Valley Brook Road
Long Valley, New Jersey 07853
Phone: (908) 876-3429

Office Use Only

CAMPER EXAMINATION FORM

Must be completed by a physician based on a Physical Exam performed on or after **8/20/08**.

G:

B:

Must be signed by a parent and physician, and returned to Meadowbrook within 60 days of enrollment. No camper will be permitted to attend camp without this form.

Name: _____ Date of Birth: _____

The above named individual was examined in my office on this date: _____

BP: _____ Height: _____ Weight: _____

In my opinion, this individual is is not able to participate in an active program.

This individual is under my care for the following condition(s): _____

MEDICATION

The above named individual takes the following medication during the winter and/or during the summer (please be specific): _____

ALLERGIES

Known Allergies:

Food(s) _____ Reaction _____

Medicine(s) _____ Reaction _____

Other _____ Reaction _____

NOTE: Allergy Action Plan Form MUST be submitted for the administration of medication.

Physician's Name _____

Physician's Phone # _____

Physician's Address _____

Physician's Signature _____

Date Signed _____

Physician Office Stamp

* _____ *

* PARENT Signature _____ Date _____ *

PLEASE COMPLETE THE REVERSE SIDE FOR IMMUNIZATION RECORDS AND AUTHORIZATION FOR NON-PRESCRIPTION MEDICATIONS

IMMUNIZATION HISTORY	Dose 1 Mo/Yr	Dose 2 Mo/Yr	Dose 3 Mo/Yr	Dose 4 Mo/Yr	Dose 5 Mo/Yr	Most Recent Dose Mo/Yr
DPT						
dT or Tdap						
Prevnar (PCV7)						
MMR						
or						
Mumps						
Measles						
Rubella						
Polio (IPV)						
HIB						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)						
Meningococcal						

AUTHORIZATION FOR NON-PRESCRIPTION MEDICATIONS

In the event of a minor medical emergency or illness, the Camp Nurse has my permission to administer the following over-the-counter medications according to the label instructions, at her discretion:

(Please circle)

- | | | |
|---------------------------------------------------------------------------------|-----|----|
| Acetaminophen (Tylenol) for discomfort, pain, fever | Yes | No |
| Cepacol lozenges for sore throat | Yes | No |
| Cortisone Cream/Ointment for skin rash on unbroken skin, insect bites | Yes | No |
| Cough Drops for irritated throat or cough | Yes | No |
| Diphenhydramine (Benadryl) for allergic reactions, hives, severe itching | Yes | No |
| Ibuprofen (Advil/Motrin) for discomfort, pain, fever | Yes | No |
| Medicaine for bee stings | Yes | No |
| Midol/Pamprin for menstrual pain (if applicable) | Yes | No |
| Orajel for toothache, dental pain | Yes | No |
| Triple Antibiotic Ointment (Neosporin) for minor wounds | Yes | No |
| Tums / Pepto Bismol for upset stomach | Yes | No |
| Zanfel for poison ivy | Yes | No |

PLEASE COMPLETE THE REVERSE SIDE FOR EXAMINATION INFORMATION AND SIGNATURES OF PHYSICIAN AND PARENT