Physician Information

These FOUR pages must be completed by a physician

To the Doctor: Please fill in this form as completely as possible. Be sure to note any condition chronic or otherwise that the camp nurses should be aware. Camp Sunrise medical staff may request further information after review of this form. Please elaborate on any identified problem.

Child's Name: _____ Date of Exam: _____ / _____ / _____

Date of Birth: ____ / ____ / _____ Gender: Male _____ Female: _____

Height: _____ Weight: _____ Temp.: _____ BP: _____ Pulse: _____

Allergies: _____

Child's clinical diagnosis: HIV: _____ AIDS _____ Other _____ None_____

Physician name: _____ Office Phone: _____

Address: _____ Office Fax: _____

_____ Emergency #: _____

_____ (on-call contact) _____

Physician: please complete the following health history information

Frequent ear infections	Yes	No
Heart defect/disease	Yes	No
Convulsions/seizures	Yes	No
Diabetes	Yes	No
Cryptosporidium	Yes	No
Chronic diarrhea	Yes	No
Persistent cough	Yes	No
Bed wetting	Yes	No
Eating disorders	Yes	No
Surgery dates:		

Chicken pox &/or shingles	Yes	No
Measles	Yes	No
Mumps	Yes	No
Asthma	Yes	No
Pneumonia	Yes	No
Herpes virus	Yes	No
Thrush	Yes	No
Weight loss	Yes	No
Night sweats	Yes	No
Bleeding disorders	Yes	No

Has the child received Varicella Vaccine? Yes/No If yes, date: _____

Is child known to be Varicella immune? Yes/No Antibody screen done? Yes/No If yes, date:_____

Has child received VZIG? Yes/No If yes, date: _____

Has child been treated for head lice in the past 6 months? Yes/No

Please list any physical disability, pertinent physical findings or *attach a recent H & P:*

Does the child require the use of:

Wheelchair _____ Walker_____ Crutches_____ Brace/Splint_____ Other_____

Restrictions (if any) _____

The following over-the-counter medications may be used to treat symptoms described underneath

For any of the following complaints using dosage recommendations on the packaging as indicated:

For headache, sore throat, fever, general discomfort, and muscle aches and pains:

- Acetominophen (Tylenol)
- Motrin (Ibuprofen)

For heartburn, upset stomach, nausea, indigestions, or other stomach complaints:

- Tums
- Mylanta
- Pepcid (famotidine)
- Prilosec (omeprazole)
- Mylanta Gas (simethicone)
- Lactaid
- Bean-O

For constipation,

- Milk of magnesia (magnesium hydroxide)
- Colace(docusate)
- Fibercon(polycarbophil)
- Ex-lax, Senokot (senna)

For minor burns, scrapes, scratches, lacerations, etc:

- Neosporin topical
- Polysporin topical
- Bactroban topical

For difficulty sleeping

- Benadryl, Nytol, Unisom(diphenhydramine hydrochloride)

For rashes caused by suspected insect bites or allergic reactions to topical irritants like poison ivy

- Caladryl
- Cortisone, Cortaid cream (hydrocortisone)

For suspected fungal infections of the feet, skin, or other body area:

- Lotrimin
- mycostatin

For diarrhea;

- Immodium (loperamide)
- Kaopectate (bismuth subsalicylate)
- Pepto bismal (bismuth subsalicylate)

For allergies, sneezing, watery eyes, itching, nasal congestion:

- Claritan (loratadine)
- Allegra (fexofenadine)
- Zyrtec(cetirizine)
- Benadryl (diphenhydramine hydrochloride)

If you disagree with a specific drug, please let us know by striking through the drug.

The above over-the-counter medications are permitted to be used for the indicated reasons in the dosages as recommended with the medication.

Physician signature _____

I give permission for the use of any of the above named medications to be administered to my child for the indicated reasons and at the dosages recommended with the medication

Parent _____

Laboratory Data

CBC	HIV Labs	Do labs need to be drawn during camp? YES/NO -- If yes, please list orders:
Date of Test:	Date of Test:	
WBC (4.5-11.0)	T-Cell count	
RBC (3.9-5.03)	Viral load	
HCT (34.9-44.5)		
Hgb (12-15.5)		
Plt (140-440)		

Vaccines	Primary Series	Booster
DPT		
Measles, Mumps, Rubella		
Polio		
Tetanus (specify type)		
Pneumococcal vaccine		
H. Flu vaccine (HIB)		
Hepatitis A		
Hepatitis B		

All immunization information must be current to date of form completion.

Tuberculosis Testing – For ALL campers (MUST BE COMPLETED BY PHYSICIAN)

TB testing information is **required** for the child's participation. A TB skin test result and/or equivalent test result must be documented within the past year. A new test is **required** if the child's last TB test was before **August 7, 2015.**

TB Skin test Date: _____ Positive/Negative

Signature of physician: _____ Date: _____ / _____ / _____

Physician Verification

I have examined the above named person and have reviewed the health history. It's my opinion that this child:

_____ is physically able to travel to camp and engage in camp activities.

_____ is NOT physically able to travel to camp, or engage in camp activities

_____ is able to travel to camp and engage in camp activities, but has restrictions as follows

Signature of physician _____