2024 Camp Grizzly Youth Leadership Camp
PHYSICAL EXAMINATION, HISTORY, and MEDICAL FORM

(Please Print):

Full Name of Applicant:______________________________ Date of Exam:________________

Birth Date (Mo/Day/Year):________________Gender: Female [ ] Male [ ] Hair Color________ Eye Color ________

Height:____________ Weight:____________ Blood Pressure: ____________ / ____________

GENERAL QUESTIONS ON HEALTH HISTORY:

Frequent Ear Infection	____Yes	____No	Asthma	____Yes	____No
Cardiovascular Disorders	____Yes	____No	Chicken Pox	____Yes	____No
Epilepsy/Seizures	____Yes	____No	Measles	____Yes	____No
Diabetes	____Yes	____No	Meningitis	____Yes	____No
Bleeding Disorders	____Yes	____No	Autism/Asperger	____Yes	____No
ADD/ADHD	____Yes	____No	Hepatitis (A,B,C)	____Yes	____No
Have a history of bed-wetting?	____Yes	____No	Skin (Rash, etc.)	____Yes	____No
Ever had an eating disorder?	____Yes	____No	Other:____________________		
Have seen a mental health professional?	____Yes	____No			

Please explain any "yes" answers above: ____

Ever had surgery ? If yes, provide dates:____

Ever been hospitalized? Provide dates:____

Loss of consciousness, convulsions or concussion? ________________________________

Any recent injury, illness, or infectious diseases?________________________________

Please provide information about the child's behavior and physical/emotional well-being that would assist the camp:

____

Does your child require a special diet?: [ ] Vegetarian [ ] Vegan [ ] Religious/Cultural [ ] Diabetic [ ] Gluten Free

Please describe: ____

ALLERGIES: [ ] Food:________________________ [ ] Drug:________________________________

Please describe the allergy reaction and management:____

MEDICATIONS: Please list all medications to be continued while at camp. All medications are secured by and administered by the Camp Nurse only.

Name of Prescription:	Dosage:	Specific times taken:	Reason:

[ ] My child does not take regular medication

IMMUNIZATION REPORT: (Please record the specific date (month/year) of the most recent booster dose for Tetanus.)

Vaccine: Tetanus (DPT /TD/ T) Date (Mo/Year):	Date of Covid Test: [ ] Negative [ ] Positive	Date of last Covid-19 booster: (not required)	Date of last TB Test: [ ] Negative [ ] Positive

ARE ALL IMMUNIZATIONS CURRENT?_____YES ______NO ****YOU MUST ATTACH A COPY OF UPDATED IMMUNIZATION RECORD****

*****NOTE: Your child will be checked for head lice and any type of contagious fungus (ie: ringworm, etc.) or fever. Your child <u>will not</u> be admitted to camp with these conditions per Camp Health Policy and Regulations and no refund will be given.**

<u>To be completed by child's physician</u>:

I have examined the camp applicant named above. In my opinion, the applicant's current health condition ___*does* ___*does not* preclude his/her participation in an active camp program. The applicant is under my care for the following condition and/or treatment:

____

Signature of Licensed Medical Personnel:____

Print Name:________________________________ Date:________________________________

Street Address:____________________City:________________ State:________Zip Code:__________

Daytime Phone:________________________________ Fax number: ________________________

2024 Camp Grizzly Over The Counter (OTC) Medication Form

California State Law requires this form to be filled out by a licensed physician for Camp Nurse (RN) to dispense over the counter non-prescription medication when needed.

Child Name: _ _________________________Birthdate (Mo/Day/Year): _______________Weight _________

All medications available in the Health Center/First Aid Kit; to be administered at the discretion of RN:

Drug	Route	Dosage	Schedule	Approved to Take (Circle)	Comments
Acetaminophen/ Tylenol	PO (chewable tabs, elixir or tabs)	Per Label	Per Label	YES / NO	
Ibuprofen/ Advil	PO (chewable tabs, suspension or tabs)	Per Label	Per Label	YES / NO	
Robitussin	PO (syrup)	Per Label	Per Label	YES / NO	
Mylanta / Tums	PO (chewable tabs, elixir or tabs)	Per Label	Per Label	YES / NO	
Dramamine	PO (chewable tabs – 50 mg)	Per Label	Per Label	YES / NO	
Dimetapp	PO (elixir or tabs)	Per Label	Per Label	YES / NO	
Benadryl	PO (chewable tabs, elixir or pills)	Per Label	Per Label	YES / NO	
Sudafed	PO (chewable tabs, elixir or pills)	Per Label	Per Label	YES / NO	
Zyrtec / Allegra / Cetirizine	PO (chewable tabs, elixir or pills)	Per Label	Per Label	YES / NO	
Claritin / Loratidine	PO (syrup or tabs)	Per Label	Per Label	YES / NO	
Mucinex DM / Guaifenesin	PO (syrup or tabs)	Per Label	Per Label	YES / NO	
Miralax	PO (powder)	Per Label	Per Label	YES / NO	
Metamucil	PO (pills, chewable tab or powder)	Per Label	Per Label	YES / NO	
Anbesol	PO (liquid)	Per Label	Per Label	YES / NO	
Visine / Visine AC	Optic drops	Per Label	Per Label	YES / NO	
Mineral Ice	Topical	Per Label	Per Label	YES / NO	
Triple antibiotic ointment	Topical	Per Label	Per Label	YES / NO	
Silvadene Cream	Topical	Per Label	Per Label	YES / NO	

The over-the-counter medications marked [Yes] above have been reviewed and approved for Camp RN to dispense.

Physician Signature: ____________________________________ Date: __________________________