



# Physical Form

Camper's parent/guardian must provide to group/church leader a statement confirming a physical examination has been performed ***within the preceding 24 months*** by a licensed physician or a certified nurse practitioner demonstrating that the camper is capable of attending camp. This can be equivalent to or copy of the camper's school or sports physical or the form below can be submitted.

Camper Name: \_\_\_\_\_

Group/Church Name: \_\_\_\_\_

Date Attending Camp: \_\_\_\_\_

## TO BE COMPLETED BY LICENSED PHYSICIAN or CNP

Medical conditions group leader should be aware of: \_\_\_\_\_

List any serious illnesses or operations and dates: \_\_\_\_\_

Special instructions (e.g. dietary restrictions, exempted activities, etc.) \_\_\_\_\_

Allergies (i.e. drugs, food, other): \_\_\_\_\_

\_\_\_\_\_ was given a physical examination on \_\_\_\_/\_\_\_\_/\_\_\_\_.

Camper is in satisfactory physical condition and capable of active participation in a camp program AT HIGH ALTITUDE, except as noted above.

Signature of Doctor or CNP: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_



# Medication Form

The designated nurse or medical distribution person with group agrees to administer medication prescribed by a licensed healthcare provider. It is the parent/guardian's responsibility to furnish the prescription medication.

**Prescription Medications** must come in a container labeled with (1) Child's Name, (2) Name of medicine, (3) Time of day to be given, (4) Dosage, (5) Date medicine is to be stopped, (6) Licensed Healthcare Provider's Name, and (7) Pharmacy Name/Phone Number.

**Over-The-Counter/ OTC** medications are stocked and used to manage common illness or injuries. These medications are dispensed by your group leader only and at their discretion. **Vitamin Supplements** Must be turned in to group leader and administered as indicated below.

Camper Name: \_\_\_\_\_

Church Name: \_\_\_\_\_

Dates Attending Camp: \_\_\_\_\_

The parent/guardian of \_\_\_\_\_ asks that the groups designated leader give  
(Child's Name)

medication/s listed below to my child, according to the Healthcare Provider's prescription instructions. By signing this document, I give permission for my child's healthcare provider to share information about the administration of my child's medication if needed while at camp with group leader designated to administer medication.

\_\_\_\_\_  
Parent/Legal Guardian's Printed Name                      Parent/Legal Guardian Signature                      Date

\_\_\_\_\_  
Work Phone                      Home/Cell Phone

## Instructions for Administering Prescription, OTC Medication & Vitamin Supplements

**Child's Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

**#1 Medication:** \_\_\_\_\_ **Dose:** \_\_\_\_\_ **Route:** \_\_\_\_\_

To be given at the following times: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Purpose of medication: \_\_\_\_\_

**#2 Medication:** \_\_\_\_\_ **Dose:** \_\_\_\_\_ **Route:** \_\_\_\_\_

To be given at the following times: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Purpose of medication: \_\_\_\_\_

Side Effects to Report: \_\_\_\_\_

**OTC Medications taken regularly and ok to administer while at camp:**

\_\_\_\_\_  
\_\_\_\_\_

**Vitamin Supplements taken regularly and ok to administer while at camp:**

\_\_\_\_\_

*Please attach additional instructions or forms if necessary.*