The Arc of Essex County
Achieve with us.

CAMP HOPE
A Program of The Arc of Essex County

CAMP HOPE PHYSICIAN'S EXAMINATION FORM – 2021

For New and Returning Campers

(TO BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN)

A COMPLETE MEDICAL/PHYSICAL EXAMINATION AFTER JULY 2020 IS REQUIRED TO ATTEND CAMP

Name of Camper/Patient: _____

I have examined the individual named on this form.

Date of last OK examination: _____

Height_____	Ears_____	Heart_____	Skin_____
Weight_____	Nose_____	Lungs_____	Scalp_____
Pulse_____	Throat_____	Abdom._____	Spine_____
BP_____	Eyes_____	Hernia_____	Extm._____

In my opinion, this individual ____is ____is not able to participate in all camping activities. They may NOT participate in the following activities:

_____

_____

The individual is under the care of a physician for the following reason:

_____

_____

Diagnosis(s): _____

MEDICATIONS:

_____This individual takes NO prescribed medications on a routine basis.

_____The following medications are ordered for the person named on this form. (If a person is on ANY medications that will be administered during camp, even Ibuprofen, a prescription must accompany medications. The prescription must specify hour of day for administration (ex. 12:00 PM, not lunchtime). The prescription must also give specific instructions for administration (ex. grind pill, open capsule, take with food, etc.)

(Over, please)

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Medication*	Administration Times / Special Instructions
Med # 1 _____	_____
Med # 2 _____	_____
Med # 3 _____	_____
Med # 4 _____	_____

*If there are additional medications, please attach a separate piece of paper

Medically prescribed diet: _____

Treatment(s) administered at camp: _____

Known allergies: _____

IMMUNIZATION RECORD (FILL THIS SECTION OUT OR SEND A CHART COPY/PRINTOUT)

****UNLESS ACCOMPANIED BY A MEDICAL OR RELIGIOUS EXEMPTION, ALL CAMPERS MUST HAVE A COMPLETED IMMUNIZATION RECORD TO ATTEND CAMP.**

	Date	
MENINGITIS		
DTP	_____	
	_____	
TD (TETANUS/ DIPHTHERIA)	_____	
TETANUS	_____	
POLIO	_____	
MEASLES/ MUMPS/ RUBELLA	_____	
CHICKEN POX	_____	
TB MONTEUX*	_____	results _____
HEPATITIS	_____	
PNEUMOCOCCAL	_____	

*Within 1 year

Additional information for health care staff at camp:

_____

Signature of physician: _____ **Date:** _____

Name of physician (please print): _____

Address: _____

Phone #: _____