# PHYSICAL EXAM FORM

****Complete when camper has been approved****

www.horizonsct.org -*forms available on our website*

**Horizons, Inc.**
**P. O. Box 323 South Windham, CT 06266**
**860-456-1032 fax: 860-456-4721**

**DATE OF PHYSICAL MUST BE WITHIN TWO YEARS OF ATTENDANCE**

Camper's Name:_____DOB:_____Age:____

Address: _____
(Street) (City, State) (Zip Code)

Medical Classification(s)/diagnosis _____

Significant past Medical History (including physical handicaps) _____

Is the camper taking any prescribed medications? Yes____ No_____ (If yes, please complete front of ivory medication form.)

Is the camper using any over-the-counter medications? Yes___ No___(If yes, please complete back of ivory medication form.)

Is this person subject to seizures? Yes_____ No_____ If yes, date of last seizure _____

Please describe seizures: When do they occur?_____for how long?_____how frequently?_____

When should parent/provider/physician be notified of seizure activity: after every seizure____ after seizure lasting_____

Medication allergies? _____ If yes, list: _____

Other allergies? _____ If yes, list:_____

Can this person participate in the following activities (in agreement with guardian and health history)
-Swimming? Yes___No___ (Lifeguard is provided)

-Row-boating? Yes___No___ (Lifejacket & lifeguards are provided)

Does this person need special considerations beyond general supervision within a 1:5 ratio during swimming, boating, or <u>any</u> other activity? Yes____ No____ If yes, please explain_____

Please list any medical concerns or treatments to be monitored at camp:

_____

Please describe any condition requiring immediate notification of parent/provider/physician:

_____

Please describe any medically prescribed meal plan or dietary restrictions, including substitute foods:

_____

Are ther any other chronic medical conditions not mentioned above that our nursing staff and/or direct care staff should be aware of including but not limited to antlantoaxial instability, communicable disease, etc.:_____

_____

PHYSICAL EXAM FORM (pg. 2) NAME_____DOB_____

**Immunization History** Required immunizations must be determined locally.
Please record the date of basic immunizations and most recent booster doses or attach immunization records.

| Vaccines | Year of Basic Immunization | Year of Last Booster |
|---|---|---|
| DPT | | |
| TD | | |
| TETANUS | | |
| Oral Polio (Sabin)* TOPV | | |
| Injectable Polio (Salk) | | |
| Measles (hard measles, red measles, Rubeola) | | |
| Mumps | | |
| Rubella (German measles, 3-day measles) | | |
| Tuberculin test given _____ ( most recent) | | |
| Haemophilus Influenza B (HIB) | | |
| Hepatitis B | | |
| Varicella (Chicken Pox) | | |
| Other | | |

☑ **Date of Physical Exam:**_____

**I certify that I have completed a physical examination of this person within the last two years on the date listed above. This person is in satisfactory condition to participate/work in an active residential camping program for and with people who have developmental disabilities. I am aware of all medications prescribed to this camper and see no contra-indications.**

***If camper should not receive one or more of the listed items, indicate by crossing through: (e.g. Benadryl)*** This person may receive over-the-counter PRN medications and/or treatments in accordance with Camp Horizons' standing orders as deemed necessary by infirmary staff and as permitted by absence of any known allergy.

| Medication | Form | | Medication | Form |
|---|---|---|---|---|
| Acetaminophen | Liquid/tablets | | Immodium | Liquid/tablets |
| Aloe | | | Maalox | |
| Aspirin | Liquid/tablets | | Milk of Magnesia | |
| Bacitracin cream | | | Mylanta | |
| Benadryl | Liquid/capsules | | Phenylephrine (Decongestant) | |
| Calamine or Caladryl lotion | | | Robitussin DM | |
| Calmoseptine (Barrier Cream) | | | Saline Rinse | |
| Cough drops | | | Senakot | Liquid/tablets |
| Epinephrine (For Emergency Only) | | | Tinactin | |
| Hydrocortisone cream | | | Tums | |
| Ibuprofen | Liquid/tablets | | | |

**PHYSICIAN/PRIMARY CARE PROVIDER'S SIGNATURE:**

_____

**PHYSICIAN'S/PCP'S NAME PRINTED**

_____

**ADDRESS**

_____

**PHONE NUMBER**