



# BUCKHORN CAMP

# DOCTOR/PARENT PHYSICAL FORM

This form MUST be completed by a licensed physician AND parent/guardian.

Remit form to: Buckhorn Camp, PO Box 125, Bellvue, CO 80512

Dates of Camp Session: \_\_\_\_\_

**CAMPER NAME:** \_\_\_\_\_ **CAMP SESSION:** \_\_\_\_\_

## MEDICAL PERSONNEL

I examined this individual on: DATE \_\_\_\_\_ BP: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_\_

In my opinion, the above individual  IS  IS NOT available to participate in an active camp program.

The applicant is under the care of a physician for the following reasons: \_\_\_\_\_

## RECOMMENDATIONS AND RESTRICTIONS AT CAMP

Treatment to be continued at camp: \_\_\_\_\_

Any medically-prescribed meal plan or dietary restrictions: \_\_\_\_\_

Known allergies: \_\_\_\_\_

## MEDICATION BEING TAKEN

Please list all medications, including over-the-counter or non-prescription drugs taken routinely. Bring enough medication to last the entire stay at camp. **\*\*\*ALL MEDICATIONS MUST BE IN THEIR ORIGINAL CONTAINER that identifies the prescribing physician (of prescription), the name of the medication, dosage, and frequency of administration.**

This person takes medication as follows:

MED #1: \_\_\_\_\_ DOSAGE: \_\_\_\_\_ SPECIFIC TIME TAKEN: \_\_\_\_\_  
 REASON FOR TAKING: \_\_\_\_\_

MED #2: \_\_\_\_\_ DOSAGE: \_\_\_\_\_ SPECIFIC TIME TAKEN: \_\_\_\_\_  
 REASON FOR TAKING: \_\_\_\_\_

MED #3: \_\_\_\_\_ DOSAGE: \_\_\_\_\_ SPECIFIC TIME TAKEN: \_\_\_\_\_  
 REASON FOR TAKING: \_\_\_\_\_

Attach additional pages for more medications/instructions. Please identify any medications taken during the school year that participant does/may not take during summer: \_\_\_\_\_

## OVER THE COUNTER MEDICATIONS • SUNSCREEN

For the camp to administer OTC Medications AND/OR apply sunscreen, Physician and Parents must check appropriate medication and dosage. Please write NO if the OTC medications listed below are not appropriate for your camper.

### For Headache/Pain/Fever:

- \_\_\_ Tylenol/acetaminophen as per package instruction
- \_\_\_ Motrin/ibuprofen as per package instruction

### For Sore Throat:

- \_\_\_ Chloraseptic Spray as per package instruction
- \_\_\_ Sucrets as per package instruction

### For Indigestion:

- \_\_\_ Mylanta or Maalox as per package instruction

### For Itching or Hives:

- \_\_\_ Caladryl Clear may be used 3-4 times per day
- \_\_\_ Benadryl Anti-itch as per package instruction
- \_\_\_ Benedryl Capsule as per package instruction

### For Cuts/Scrapes/Abrasions:

- \_\_\_ Triple Antibiotic cream may be used 2-3X's/day

### Sunscreen:

- \_\_\_ Banana Boat Sport or Kids Sunscreen 50 SPF Broad-spectrum (or equivalent)

### PLEASE CHECK ONE:

- Counselor/Camp Staff May Apply Sunscreen to My Camper
- Counselor/Camp Staff May Supervise but NOT Apply to My Camper

**Signature of Licensed Medical Personnel:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Office Address:** \_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_