

Conferee Name: _____

*** The physical exam is valid for three years from the date of the physician signature. Please update health history annually. ***

ANY SPECIAL CONCERNS THE CAMP NURSE SHOULD BE AWARE OF: _____

HEALTH HISTORY:

Allergies to medications, foods or other: (bee stings, hay fever, asthma, penicillin, poison ivy, etc.)

Any/all medications being taken: (For any medication not listed on the STANDING ORDERS form please have a physician complete a PHYSICIANS ORDER form.) Keep all medications in original bottles

List any restrictions (physical, dietary, other)

MEDICAL HISTORY: (explain any "yes" answers below)

	yes	no		yes	no
Had any recent injury, illness or infectious disease?	___	___	Have diabetes?	___	___
Prone to Ear Infections?	___	___	Abnormal menstrual(female)	___	___
Ever been hospitalized?	___	___	Heart murmur?	___	___
Ever had surgery?	___	___	Back problems?	___	___
Treated for Mental Illness?	___	___	Skin problems?	___	___
Treated for Depression?	___	___	Asthma?	___	___
Ever had seizures?	___	___	Eating disorder?	___	___
Ever had high blood pressure?	___	___	History of bed-wetting?	___	___
			Stomach problems?	___	___

Please explain any "yes" answers: _____

Which of the following has the participant had?

- ___ Measles
- ___ Chicken Pox
- ___ German Measles
- ___ Mumps
- ___ Hepatitis
- ___ Varicella Zoster

Please give date for last immunization for:

- ___ DTP
- ___ Polio
- ___ Mumps
- ___ Rubella
- ___ Chickenpox
- ___ Hepatitis B
- ___ Measles

*** MUST BE COMPLETED BY A LICENSED PHYSICIAN***

PHYSICAL EXAM: Code (1) Satisfactory (2) Not Satisfactory

Height _____ Weight _____ BP _____ Skin _____ Nose _____ Teeth _____
 Eyes _____ Glasses _____ Contacts _____ Required _____ Condition _____
 Ears _____ Hearing: Right _____ Left _____ Throat _____ Heart _____
 Abdomen _____ Genitalia _____ Hernia _____ Extremities _____

Tests: Urinalysis glucose _____ Albumin _____ Tuberculin Testing (type) _____

The above named person is in satisfactory condition and may engage in all camp activities.

____/____/____ Date of Last Exam: Physician Signature: _____

Print Physician Name: _____ Lic# _____ State Licensed in: _____

Address _____ City _____ Telephone# (____) _____

Conferee Name: _____

SILVER LAKE CONFERENCE CENTER STANDING ORDERS

Standing orders are non-prescription medications that our Conference Center pediatrician has recommended for a variety of common ailments in age specific doses.

Parents/Guardians are required to initial the box next to any medication from our standing orders that they **DO NOT** want administered to their child when indicated.

Medication	Initial
Bacitracin	
Neosporin	
Betadine	
Daciase (eye solution)	
Tylenol	
Ibuprofen	
Aloe Lotion	
<i>Solarcaine Spray</i>	
<i>Benadryl</i>	
Calamine lotion	
Hydrocortisone cream	
Imodium AD	
Kaopectate	
Cortisporin ear drops	
Cepacol lozenges	
Milk of Magnesia	

Medication	Initial
Dulcolax	
Anbesol	
Oragel	
Mylanta	
Tums	
Coricidin	
Coricidin D	
Sudafed	
Sudafed Longacting	
Triaminic	
Dimetapp	
Robitussen DM	
Epinephrine HCL (for severe asthma attacks)	
Rhuligel	
Albuterol/Nebulizer treatment (Pulmo-aide)	

I understand that the above list of medications is part of the Standing Orders for the Silver Lake Health Center and I have initialed the box next to all medications I **DO NOT** want my child to be treated with:

Parent/Guardian Signature

Date