Physical Examination Form

Physical Examination must be completed by a licensed medical physician or nurse practitioner within twelve (12) months of camper attending camp. **All campers must have this form completed and uploaded to their online registration prior to their arrival at camp.** Campers cannot be admitted without it. To upload form, visit www.eaglelakecamps.com and login to your registration account.

Camper Name _____ _____
First *Last*

Name of Family Physician _____ **Insurance Carrier** _____

Insurance Group Number _____ **Insurance Plan Name** _____
i.e. PPO, HDHP, etc.

Health Care Recommendations by Licensed Medical Personnel

I examined this individual on (date) _____ BP_____ Weight _____ Height_____.

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions

_____

_____

Medicines Being Taken (prescription and non-prescription)

IMPORTANT: Medicines will only be administered to the camper with written authorization given to the camp by the child's physician.

Please list **ALL** medicines (including prescription drugs, over-the-counter medicines, vitamins, or supplements) that the camper will take at camp. Eagle Lake Camps will administer only medicines with written instructions from the camper's physician (or medicines listed in the camp's written standing orders). Bring enough medication to last the entire time at camp. **Keep it in the original packaging/bottle** that identifies the prescribing physician (if a prescription drug), and the name of the medicine. *Please note our infirmary is sufficiently stocked with over-the-counter medications to meet the demands of most headaches, coughs, and scrapes.*

☐ This person takes NO medications (on a routine basis).

☐ This person takes medications as follows:

Med #1_____Dosage_____Specific time taken each day_____

Instructions for administering (must be written by physician) _____

Med #2_____Dosage_____Specific time taken each day_____

Instructions for administering (must be written by physician) _____

Med #3_____Dosage_____Specific time taken each day_____

Instructions for administering (must be written by physician) _____

Med #4_____Dosage_____Specific time taken each day_____

Instructions for administering (must be written by physician) _____

Recommendations and Restrictions at Camp

Treatment to be continued at camp_____

_____

Any medically-prescribed meal plan or dietary restrictions_____

_____

Known allergies_____

_____

Description of any limitation or restriction on camp activities_____

_____

Additional information for health care staff at Eagle Lake Camp_____

_____

Please attach copy of camper's immunization record

(This is a requirement of State of Colorado; camper cannot be admitted without immunization record.)

Signature of Licensed Medical Personnel (required)_____

Printed_____Title_____

Address_____

Phone_____Date_____

For camp use only

Screening Record

Date screened_____Time_____ am pm

Meds received_____

Current health needs identified_____

_____

CERTIFICATE OF IMMUNIZATION
www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

Colorado law requires this form to be completed by a school health authority or health care provider for each immunized student attending Colorado schools.

6 CCR 1009-2 The Infant Immunization Program and Immunization of Students Attending School: Schools shall have on file an official immunization record for every student enrolled.

Name: _____ **Date of birth:** _____

Parent/guardian: _____

Required vaccines

	Each immunization date MM/DD/YY						**Titer date**
Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
DT Diphtheria, Tetanus (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella date of disease	
Varicella positive screen date	

Recommended vaccines

	Each immunization date MM/DD/YY					
HPV Human Papillomavirus						
Rota Rotavirus						
MCV4/MPSV4 Meningococcal						
Men B Meningococcal						
Hep A Hepatitis A						
Flu Influenza						
Other						

Optional review signature by the school health authority or health care provider
I have reviewed this immunization record

Signature: _____ Date: _____

(Optional) TO BE COMPLETED BY PARENT/GUARDIAN/ADULT STUDENT
I authorize my/my student's school to share my/my student's immunization records with state/local public health and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Signature: _____ Date: _____