**CONQUEST**
FORGED IN VIRTUE. CALLED TO SERVE.
CATHOLIC YOUTH MINISTRY

# 2018 Physician and Parent Examination Form

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

Camper's Name:____________________ ________________________________
First Last

Dates of Attendance: HS Girls (6/15-6/23)____ MS Girls (6/18-6/23)____

***To be completed by 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: ______________________

**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 time at camp. ***All medications including over-the counter must be in their original container that identifies the prescribing physician (if prescription), the name of the medication, dosage, and frequency of administration**

This person takes medications as follows:

Med #1__________________________________ Dosage_________________________ Specific times taken each day______________

Reason for taking____________________________________________________________________________________________

Med #2__________________________________ Dosage_________________________ Specific times taken each day______________

Reason for taking____________________________________________________________________________________________

Med #3__________________________________ Dosage_________________________ Specific times taken each day______________

Reason for taking____________________________________________________________________________________________

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during summer:__________________________

________________________________________________________________________________________________________

## Over the Counter Medications: For the camp to administer OTC Medications, Physician and Parents must check appropriate medications and dosages. Please write "NO" if not appropriate:

**For Headache / Pain / Fever:**
______ Tylenol / acetaminophen as per package instruction
______ Motrin / ibuprofen as per package instruction

**For Sore Throat:**
______ Chloraseptic Spray as per package instructions
______ Sucrets as per package instructions

**Indigestion:**
______ Mylanta or Maalox as per package

**For Itching or Hives:**
______ Caladryl Clear may be used 3 – 4 times a day
______ Benadryl Anti-itch as per package instruction
______ Benadryl Capsule as per package instruction

**For Cuts, Scrapes, and Abrasions:**
______Triple Antibiotic cream may be used 2 – 3 times a day

**Signature of Licensed Medical Personnel:**________________________________________

Date____________Printed Name___________________________Title ____________________

Address________________________________________ Phone_________________________________

**Signature of Parent / Guardian:** ____________________________________________________________

Date ________________________Printed Name_______________________________________