Malibu Beach Camp **Physician's Report 2022**

All information will be held in the strictest confidence; please be as thorough as possible.

Child's Name:_____ **Date of Birth:**_____

Date _____ Weight _____ Height _____

Blood Pressure _____ Urine_____ Hematocrit _____

Mother's Name:_____ **Father's Name:** ___

Mother's Phone#(house):_____ **Father's Phone#(house):** _____

Mother's Phone#(cell):_____ **Father's Phone#(cell):** _____

Emergency Contact#1

Name: _____ **Relationship:** _____ **Phone #** _____

Emergency Contact #2

Name: _____ **Relationship:** _____ **Phone #** _____

Emergency Contact #3

Name: _____ **Relationship:** _____ **Phone #** _____

Health Care Recommendations by Licensed Physician

***The Health Department requires that a physical exam was completed no more than a year prior to the last day of camp, 8/20/22.**

Date of Last Physical Exam: _____

Is the camper able to participate in an active camp program? _____ Yes _____ No

Camper is under the care of a physician for the following condition(s):_____

_____

Current treatment (include current medications):_____

_____

Explanation of any reported loss of consciousness, convulsion, or concussion: _____

_____

Child's name _____ **Date of Birth** _____

Are there any…

Allergies (food, drugs, plants, insects, etc)? If yes, please explain:_____

_____

If yes, should exposure occur, how should the allergic reaction be treated?
_____

If this is an anaphylactic response, will this child's parents supply an epinephrine device?

_____ _____

Cardiovascular conditions? _____

Respiratory conditions? _____

Middle ear conditions?_____

Gastrointestinal conditions? _____

Neurological conditions? _____

Are there any…

Activity restrictions?_____

Orthopedic conditions? _____

Special diet? _____

Treatment(s) to be continued at camp? _____

Medication(s) to be administered at camp? _____

Same as during the school year? _____

Additional medical or psychological conditions not listed that we should be aware of?_____

_____

Child's name _____ **Date of Birth** _____

Camper Immunization History

Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
DPT Series, Diphtheria, Pertussis, Tetanus OR	1 2 3	1 2 3
TD Series, Tetanus, Diphtheria OR		
Tetanus		
Polio Series		
MMR Series		
HIB Series		
Hepatitis B Series		
Chicken Pox (illness or vaccine)		
Meningitis		
Other		

****A copy of the immunization report from your child's physician may be attached to this paper.**

We may have neglected to ask something you feel is needed to adequately address the health needs of this child. If that is the case, please add your comments. _____

_____

_____

_____

Licensed Physician's Name_____

Physician's Signature _____

Physician's Address _____ Phone _____

Date of Form Completion_____ *By_____

**Initial if completed by nurse or physician's assistant.*

PRN Over -The -Counter Medications

Camper Name: _____ Date of Birth _____

PRN medications are over-the-counter medications that can be administered by camp medical personnel if approval is indicated by a camper's healthcare provider or parent. Administration, dosage, and schedule of the following medications will be determined based on the manufacturer's instructions as appropriate for the camper's age, weight, etc. unless otherwise specified on this form.

Generic equivalents of the following medications may also be given. Please indicate if your child is allergic to any generic or name-brand medication.

Medication Over-The-Counter	Administration	Alternate Medication or Special Instructions
Bacitracin/Neosporin	☐ Yes ☐ No	
Hydrocortisone Cream/Ointment	☐ Yes ☐ No	
Saline/Eye Wash	☐ Yes ☐ No	
Hydrogen Peroxide	☐ Yes ☐ No	
Rubbing Alcohol	☐ Yes ☐ No	
Benadryl Itch Stopping Gel	☐ Yes ☐ No	
Calamine Lotion	☐ Yes ☐ No	

Parent's Signature:_____ Date: _____

******PLEASE COMPLETE AND RETURN TO THE CAMP OFFICE BY May 1st.*****

Prescription Medications

Camper Name: _____ Date of Birth _____

<u>Please have your child's physician</u> fill out this form if you wish Malibu Beach Camp medical personnel to administer a prescribed medication to your child that is not on the PRN Over The Counter Medications List (i.e. Epi-Pen, Inhaler, Benadryl, etc.)

I _____(Parent's name), give permission to Malibu Beach Camp medical personnel to administer _____ (medication name) _____ (medication name) _____ (medication name)

to my child under the following circumstance: _____.
The dosage that should be given is:
_____.

Parent's Signature:_____ Date: _____
Physician's Name: _____Physician's Signature: _____

******PLEASE COMPLETE AND RETURN TO THE CAMP OFFICE BY May 1st.*****