Please Return to: Camp Sam USA, C/o Missy Klippert, 5904 Emperor Way, Las Vegas, NV 89130 By July 1st.

Nurse Andrea and Campers
Camp Sam

Medical Physical Forms

This entire form must be completed and signed by both parent/guardian and licensed physician.

IN ORDER FOR CAMPER TO PARTICIPATE IN CAMP THIS FORM MUST BE RETURNED BY JULY 1

The information on this form is not part of the camper acceptance process, but is gathered to assist us in identifying appropriate care.

Required signatures:

- Parent/guardian signatures required at the end of Section 1 and Section 2
- Physician signature/information required on Section 3, Page 4.

All medications must be written on the Medical Form including such items as Tylenol, vitamins, inhalers, Tums, etc. It is imperative that all medications, both prescription and over the counter, be in their original containers, labeled with your camper's name. The Nurse carries Tylenol, Pepto Bismal and Benedryl should your camper need it. They will supply those meds. Please do not bring those up with your camper.

Section 1: Camper Demographics/ Insurance Information:

Camper Name: _____ Sex: _____ Birth date:_____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Parent/guardian: _____ Phone: _____

Insurance Company: _____ Policy Number: _____Expiration: _____

In the event that I cannot be reached in an emergency, I hereby authorize Camp Sam personnel to secure proper treatment for my child/camper, including but not limited to: injections, X-rays, anesthesia, surgery and hospitalization. By granting this authorization, I further agree to indemnify and hold harmless Camp Sam, its employees and agents from any damage, illness or death resulting from participation in the Camp Sam Camp, located at Camp Lee Canyon Camp. I also agree to the release of any records necessary for insurance purposes or medical treatment.

Parent/Guardian Signature: _____**Date**:_____

Section 2: Camper Health Information:

Has/does the participant:	Yes	No	if yes please explain*
1. Had any recent injury, illness or infectious disease?.....	____	____	_____
2. Have a medically prescribed meal plan or dietary restrictions?	____	____	_____
3. Have a chronic or recurring illness/condition?.....	____	____	_____
4. Have frequent headaches?.....	____	____	_____
5. Ever had a head injury/been knocked unconscious?.....	____	____	_____
6. Ever had frequent ear infections?.....	____	____	_____
7. Ever had a seizure?.....	____	____	_____
8. Ever had high blood pressure/diagnosed heart murmur?.....	____	____	_____
9. Ever had an orthopedic or back problem?.....	____	____	_____
10. Have diabetes?.....	____	____	_____
11. Have asthma?.....	____	____	_____
12. Have seasonal/environmental allergies?.....	____	____	_____
13. Had problems with diarrhea/constipation?.....	____	____	_____
14. Have problems with sleepwalking?.....	____	____	_____
15. Have a history of bed-wetting?.....	____	____	_____
16. Ever had an eating disorder?.....	____	____	_____

Any Additional health information about the above mentioned camper that will help staff should be mentioned * *Please attach extra page if necessary*

Continue Medical Questions on Next Page…

Section 3: Camper Medication Information:

Medications and Authorization to Assist with Administration

Please list ALL medications (including over-the-counter medications, nonprescription drugs and vitamins) taken routinely. Parent/guardian must send enough medication to last the entire time at camp. ALL medications must be turned into the camp nurse **IN THE ORIGINAL CONTAINER** (with the prescribing doctor and administration orders of a prescription) at the time of check in. Medications without the original container/prescription WILL NOT BE ACCEPTED (this includes inhalers) Bubble packs accepted with correct dates..

MEDICATION	Rx or OTC (Circle one)		DOSE	FREQUENCY	TIME (S)	ROUTE
	Rx	OTC				
	Rx	OTC				
	Rx	OTC				
	Rx	OTC				
	Rx	OTC				
	Rx	OTC				

Special administration instructions:

*Medication that is not listed above and reviewed by camp health personnel prior to camp, but is needed at the time of camp, MUST be accompanied by a doctor's prescription. This includes over-the-counter medication.

I hereby authorize administration of the above medication(s) to my child/dependent while they are at a Camp Sam USA Camp. If no Meds are listed I am signing that I understand my camper has no listed medication. I understand that Camp Sam and its employees and agents will not be held liable for any injury to my child or any other camper caused by any medication that is not surrendered to the camp medical staff at the time of check in.

Parent/Guardian Signature: _____ **Date:** _____

THIS PAGE TO BE COMPLETED BY PHYSICIAN

Physical Examination: (Physician please review and confirm information on previous 2 pages before signing below)

Examination	Normal/ Results	Abnormal Findings	Explain
Appearance			
Height			
Weight			
Temperature			
Heart Rate			
Blood Pressure			
Eyes/Ears/ Nose/Throat			
Lymph Nodes			
Teeth			
Lungs			
Heart			
Abdomen			
Skin			
Posture			
Range of Motion			

1.Participant cleared for activities while at Camp Lee Canyon which is situated at an elevation of 8,500 ft. Activities may include hiking, running, climbing or dancing: **YES / NO**

Activity restrictions: _____

3. I have reviewed pages all 3 pages of this medical form and concur with parent/guardian's requested medications and description of health status: **YES / NO**

Name of physician (print/type): _____ **Phone:**_____

Physician Signature _____ **Date** _____

Please continue to the last page of the medical form: Contraindications Form….

CAMP SAM-Over the Counter Medication Request

Must be filled out and signed by physician

PARTICIPANT NAME: _____ **DOB:** _____

Please be advised that Over the Counter Medications can NOT be administered to campers of Camp Sam without a licensed healthcare provider or physician's order/prescription. While we will have stock acetaminophen (Tylenol), diphenhydramine (Benadryl), and Pepto-Bismol on hand, without explicit physician or licensed healthcare provider orders, your camper will not be allowed to have these medications.

Please have the physician for your Camp Sam participant sign and date for the following over the counter medications.

Acetaminophen (Tylenol): Dose: _____ Route: _____

Frequency: _____/PRN Needed for: _____

Contraindications: _____

Diphenhydramine (Benadryl): Dose: _____ Route: _____

Frequency: _____/PRN Needed for: _____

Contraindications: _____

Pepto-Bismol: Dose: _____ Route: _____

Frequency: _____/PRN Needed for: _____

Contraindications: _____

Other over the counter medications needed, but not provided by Camp Sam, must ALSO have physician orders:

Medication: _____ Dose: _____ Route: _____

Time: _____ or PRN

Frequency: _____ Needed for: _____

Medication: _____ Dose: _____ Route: _____

Time: _____ or PRN

Frequency: _____ Needed for: _____

Licensed Healthcare Provider Name: _____ **Office Number:** _____

Licensed Healthcare Provider Signature: _____

Date: _____