# Annual Physical Form

Rotary Camp
For Children with Special Needs

Camper's Name _____

Date of Birth _____

Today's Date _____ Last Physical Date _____

Height _____ Weight _____

**Please return completed form to:**
Akron Rotary Camp
4460 Rex Lake Drive
Akron, OH 44319
330.644.1013 (fax)
rotarycamp@akronymca.org (email)

Questions/comments? Please contact us at 330.644.4512

www.gotcamp.org/rotary

The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. ***Please cross out those items the camper should not be given.***

Acetaminophen (Tylenol)
Ibuprofen (Advil, Motrin)
Phenylephrine (Sudafed PE)
Pseudoephedrine (Sudafed)
Chlorpheneramine maleate
Guaifenesin
Dextromethorphan
Diphenhydramine (Benadryl)
Generic cough drops
Chloraseptic (Sore throat spray)
Lice shampoo or scabies cream (Nix or Elimite)
Calamine lotion
Bismuth subsalicylate (Pepto-Bismol)
Laxatives for constipation (Ex-Lax)
Hydrocortisone 1% cream
Topical antibiotic cream
Calamine lotion
Aloe

**Medications** ___No daily medications
___Will take the following prescribed medications

Name of Medication Dosage Times/Meals

a. _____

b. _____

c. _____

d. _____

e. _____

**Immunization History:** Provide the month and year for each immunization. Starred (*) immunizations must be current. Copies of immunizations forms from health-care providers or state or local government are acceptable; please attach to this form.

| Immunization | Dose 1 | Dose 2 | Dose 3 | Dose 4 | Dose 5 | Most Recent |
|---|---|---|---|---|---|---|
| Diptheria, tetanus, pertussis * (DTaP) or (TdaP) | | | | | | |
| Tetanus booster * (dT) or (TdaP) | | | | | | |
| Mumps, measles, rubella (MMR) | | | | | | |
| Polio (IPV) | | | | | | |
| Haemophilus influenza type B (HIB) | | | | | | |
| Pneumococcal (PCV) | | | | | | |
| Hepatitis B | | | | | | |
| Hepatitis A | | | | | | |
| Varicella (chicken pox) ☐ Had chicken pox Date: | | | | | | |
| Meningococcal meningitis (MCV4) | | | | | | |

| Tuberculosis (TB) test | Date | ___Negative | ___Positive |
|---|---|---|---|

This camper is undergoing treatment for the following condition(s) (Please describe below): ____None

Diet/Nutrition: ____Eats a regular diet ____Has a medically prescribed diet (please describe below):

Other treatment/therapies to be continued at camp (please describe below): ____None

Please describe any limitations or restrictions that the camper may have while at camp:

**I have discussed the camp program with the camper's parent(s)/guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).**

Name of licensed provider (please print): _____Signature: _____Title: _____

Office Address_____
Street City State Zip Code

Telephone: (_____)_____ Date:_____