

# 2011 Kamp Kiwanis®

## Staff Health Exam by a Kamp RN

**This form or a similar one must be completed to attend Kamp Kiwanis**



**2011 MEDICAL EXAMINATION (RN TO COMPLETE):**

Name \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

BP \_\_\_\_\_ P \_\_\_\_\_ Vision R20/ \_\_\_\_\_ L20/ \_\_\_\_\_ Ears \_\_\_\_\_ Throat \_\_\_\_\_ Teeth \_\_\_\_\_ Skin \_\_\_\_\_

Respiratory \_\_\_\_\_ Cardiovascular \_\_\_\_\_ Musculoskeletal \_\_\_\_\_ Neurological \_\_\_\_\_

Liver \_\_\_\_\_ Spleen \_\_\_\_\_ Genitalia \_\_\_\_\_ Hernia \_\_\_\_\_ U/A \_\_\_\_\_ Asthma \_\_\_\_\_

The patient is under the care of a physician for the following condition(s): \_\_\_\_\_  
 Comments: \_\_\_\_\_

**INDIVIDUALIZED ORDERS:** The following non-prescription medications are commonly stocked in the Kamp Health Center and are used on an as needed basis to manage illness and injury.  
**Medical personnel: Cross out those items the camper should not be given.**

Aloe  
 Antacids  
 Auralgan (Ear Drops)  
 Bismuth Subsalicylate (Pepto-Bismol)  
 Calamine Lotion  
 Chloraseptic (Sore throat spray)  
 Chlorpheniramine maleate  
 Cough Suppressants  
 Decongestants (Sudafed & Sudafed PE)  
 Diphenhydramine (Benadryl)  
 Guaifenesin (Robitussin any form)  
 Laxatives for constipation  
 Lice shampoo  
 Pain reliever/fever reducer: Acetaminophen/Ibuprofen  
 Scabies cream  
 Topical Antibiotics: Bacitracin/Neosporin/Bactroban  
 Topical Antipruritics: Calagel/Hydrocortisone/Benadryl

### ALLERGIES AND DIET

**ALLERGIES:**  No Known Allergies

To foods (**list**):

To Medications (**list**):

To the environment, (**insect stings to include bees, hay fever, etc. list**):

Other Allergies (**list**):

**DIET:**

Eats a regular diet

Has a medically prescribed meal plan or dietary restrictions (**list**):

**PRESCRIPTION MEDICATIONS AND TREATMENTS:** Please complete with Patient's current regimen for both scheduled and PRN medications to include peak flows, nebulizer treatments, blood draws/lab work, diabetic testing, insulin administration, dressing changes, via GT etc.; please use the back sheet for additional medications as need.

Name of Medication	Date Started	Reason for taking it	When is it given	Amount or dose given	How is it given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time		

**LIMITATIONS ON ACTIVITY:**  
 Swimming \_\_\_\_\_ Hiking \_\_\_\_\_ Athletics \_\_\_\_\_ Canoeing \_\_\_\_\_ Other: \_\_\_\_\_ Explain: \_\_\_\_\_

I certify that I have on this date examined the above named and that on the basis of my examination and medical history as furnished to me, I have found no reason which would make it medically inadvisable for the camper to participate in physically strenuous activities.

RN's Signature \_\_\_\_\_ Date \_\_\_\_\_ Date of Examination \_\_\_\_\_

Please Print: RN's Name \_\_\_\_\_ License # \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

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Additional Medications**

Name of Medication	Date Started	Reason for taking it	When is it given	Amount or dose given	How is it given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time		
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