**The Rochester Rotary Sunshine Camp**

**PHYSICIAN FORM**

**Fax 585-533-1810**

**Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name \_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Please ATTACH a copy of immunizations and physical exam**

**DIAGNOSIS (s)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other physical, mental, or emotional problems or diseases of which the medical staff should be aware of**

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**Does the Camper have or has have seizures?** \_\_\_\_Yes \_\_\_\_No **If yes what** **type?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESTRICTIONS: Are there any restrictions on using the pool or participating in sports?** \_\_\_\_Yes \_\_\_\_No

**If yes please describe**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Food and/or drug allergies?** \_\_\_\_Yes \_\_\_\_No

**If yes please describe**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following over the counter medication or generic equivalent is available in the Sunshine Campus Infirmary. If determined to be necessary will be administered at the discretion of the medical staff. The medications will be administered “per label direction” unless otherwise specified.

|  |  |  |
| --- | --- | --- |
| **Drug Name** | **Provider Order** | **Physician’s Comments** |
| Tylenol (discomfort/fever) | YES or NO |  |
| Advil (discomfort/fever) | YES or NO |  |
| Throat Lozenges (throat irritation, cough) | YES or NO |  |
| Benadry (allergies) | YES or NO |  |
| Claritin (allergies) | YES or NO |  |
| Zyrtec (allergies) | YES or NO |  |
| Chloraseptic Spray (throat irritation) | YES or NO |  |
| Cortizone Cream (topical) for skin irritation | YES or NO |  |
| Saline eye drops/wash | YES or NO |  |
| Tums (heartburn/stomach upset) | YES or NO |  |
| First Aid Cream/Neosporin (topical-cuts and scrapes) | YES or NO |  |
| Lotrimin | YES or NO |  |
| Calamine Lotion | YES or NO |  |
| Miralax | YES or NO |  |

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|  |  |  |  |
| --- | --- | --- | --- |
| **Medication and Strength** | **Dose** | **Route** | **Time to be given** |
| Example: Ritalin 5mg | 7.5mg | By mouth | 8 am and 12pm |
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***PLEASE REVIEW MEDICATIONS WITH YOUR CHILDS PROVIDER AND SIGN BELOW- THIS MUST BE SIGNED BY BOTH THE PARENT/GUARDIAN AND MEDIAL PROVIDER******PRIOR TO YOUR CHECK IN. INACCURATE INFORMATON WILL DELAY YOUR CHECK IN.***

Parent Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_/\_\_\_\_/\_\_\_\_

Medical Provider Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date**\_\_\_\_/\_\_\_\_/\_\_\_\_**

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

Office Fax #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Hospital? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_