

# PHYSICAL FORM

Complete for Timberline, Teen, and LAST camps.  
Must be received two weeks prior to your camp.



Camper Name \_\_\_\_\_

Week of Camp \_\_\_\_\_

**This section must be completed by camper's physician or PA. (RN is not acceptable.)**

Are there any significant medical events in the camper's medical history that should be brought to the attention of the Camp Eden medical staff?

Are there any existing medical conditions that should be brought to the attention of the Camp Eden medical staff?

Are there any allergic conditions (medications/food/other) that should be brought to the attention of the Camp Eden medical staff?

Are there any camp activities in which this camper should not participate?

I, the examining physician, hereby authorize the properly qualified personnel of Camp Eden to administer the medications prescribed for the above camper. I have examined this camper and found him/her to be in satisfactory condition and capable of active participation in a regular camp program except as noted above.

Signature of Doctor \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Printed Name \_\_\_\_\_

Doctor's Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone \_\_\_\_\_

## Immunization Record

The State of Colorado requires all campers to submit a complete set of immunization records or a legal exemption. Please attach certificate of immunization or complete the following (with date of immunization):

DPT \_\_\_\_\_ DT \_\_\_\_\_ Polio \_\_\_\_\_ MMR \_\_\_\_\_ Hepatitis B \_\_\_\_\_

HIB \_\_\_\_\_ Other: \_\_\_\_\_

# MEDICATION FORM

Complete for Timberline, Teen, and LAST camps.  
Must be received two weeks prior to your camp.



Camper Name \_\_\_\_\_

Week of Camp \_\_\_\_\_

## Medication Authorization

By signing the line below, you give Camp Eden permission to allow your camper to keep their inhaler/epi-pen with them while at Camp Eden and for either your camper or authorized Camp Eden personnel to administer said inhaler/epi-pen as needed. You also give permission for Camp Eden medical personnel to distribute both Rx medication and over-the-counter medication as specified by parent/guardian or as authorized by doctor's standing orders.

\_\_\_\_\_  
(Parent or Guardian's Signature)

## Prescription Medication (Please list ALL medications!)

State regulations require camps to collect all medications at registration. Please keep all medications in the **original container** that provides the camper's name, prescribing physician, the name of the medication, the dosage, and the frequency of use. All medications including prescription, non-prescription, vitamins, homeopathic medications, natural remedies, and herbs must be accompanied by a physician's prescription with his/her signature in order for our medical staff to administer the medication during the camp week. **Use an additional Medication Form if camper takes more than three medications.**

Name of Medication:	<b>Mon</b>	<b>Tues</b>	<b>Wed</b>	<b>Thurs</b>	<b>Fri</b>	<b>Sat</b>
Start Date:      End Date:		<input type="checkbox"/> Breakfast	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Breakfast
Dosage:              Frequency:		<input type="checkbox"/> Mid-Morning	<input type="checkbox"/> Mid-Morning	<input type="checkbox"/> Mid-Morning	<input type="checkbox"/> Mid-Morning	
Purpose for Medication:		<input type="checkbox"/> Lunch	<input type="checkbox"/> Lunch	<input type="checkbox"/> Lunch	<input type="checkbox"/> Lunch	
		<input type="checkbox"/> Afternoon	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Afternoon	
	<input type="checkbox"/> Dinner	<input type="checkbox"/> Dinner	<input type="checkbox"/> Dinner	<input type="checkbox"/> Dinner	<input type="checkbox"/> Dinner	
(Please complete usage chart to the	<input type="checkbox"/> Before Bed	<input type="checkbox"/> Before Bed	<input type="checkbox"/> Before Bed	<input type="checkbox"/> Before Bed	<input type="checkbox"/> Before Bed	

Name of Medication:	<b>Mon</b>	<b>Tues</b>	<b>Wed</b>	<b>Thurs</b>	<b>Fri</b>	<b>Sat</b>
Start Date:      End Date:		<input type="checkbox"/> Breakfast	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Breakfast
Dosage:              Frequency:		<input type="checkbox"/> Mid-Morning	<input type="checkbox"/> Mid-Morning	<input type="checkbox"/> Mid-Morning	<input type="checkbox"/> Mid-Morning	
Purpose for Medication:		<input type="checkbox"/> Lunch	<input type="checkbox"/> Lunch	<input type="checkbox"/> Lunch	<input type="checkbox"/> Lunch	
		<input type="checkbox"/> Afternoon	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Afternoon	
	<input type="checkbox"/> Dinner	<input type="checkbox"/> Dinner	<input type="checkbox"/> Dinner	<input type="checkbox"/> Dinner	<input type="checkbox"/> Dinner	
(Please complete usage chart to the right.)	<input type="checkbox"/> Before Bed	<input type="checkbox"/> Before Bed	<input type="checkbox"/> Before Bed	<input type="checkbox"/> Before Bed	<input type="checkbox"/> Before Bed	

Name of Medication:	<b>Mon</b>	<b>Tues</b>	<b>Wed</b>	<b>Thurs</b>	<b>Fri</b>	<b>Sat</b>
Start Date:      End Date:		<input type="checkbox"/> Breakfast	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Breakfast	<input type="checkbox"/> Breakfast
Dosage:              Frequency:		<input type="checkbox"/> Mid-Morning	<input type="checkbox"/> Mid-Morning	<input type="checkbox"/> Mid-Morning	<input type="checkbox"/> Mid-Morning	
Purpose for Medication:		<input type="checkbox"/> Lunch	<input type="checkbox"/> Lunch	<input type="checkbox"/> Lunch	<input type="checkbox"/> Lunch	
		<input type="checkbox"/> Afternoon	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Afternoon	
	<input type="checkbox"/> Dinner	<input type="checkbox"/> Dinner	<input type="checkbox"/> Dinner	<input type="checkbox"/> Dinner	<input type="checkbox"/> Dinner	
(Please complete usage chart to the right.)	<input type="checkbox"/> Before Bed	<input type="checkbox"/> Before Bed	<input type="checkbox"/> Before Bed	<input type="checkbox"/> Before Bed	<input type="checkbox"/> Before Bed	

## Over-the-Counter Medications

Camp Eden stocks over-the-counter medications which are used to manage common illness and injuries. These medications are dispensed by qualified health personnel as directed by standing orders signed by the Camp Eden supervising medical personnel.

The following medications, available at Camp Eden, may be administered by Camp Eden personnel in order to relieve minor pain and discomfort. Place an "X" after any medications that **SHOULD NOT** be administered to your camper.

Acetaminophen (Tylenol)	No ___	Hydrogen peroxide	No ___
Antibiotic Ointment	No ___	Ibuprofen (Advil)	No ___
Benadryl	No ___	sun screen	No ___
Cough drops	No ___	Tums (or other anti-nausea)	No ___
Eye drops	No ___	Pepto-Bismol	No ___
Hydrocortisone 1%	No ___		