

**Dream Oaks Camp Health Examination**

**DATE** \_\_\_\_\_

**Mail To:**  
**Foundation for Dreams, Inc.**  
**7359 Merchant Court**  
**Sarasota, FL 34240**  
**(941) 907-1111**  
**Fax: (941) 907-1112**

**Campers Name** \_\_\_\_\_

**Parents Name** \_\_\_\_\_

**This Health Examination Form for Camp must be completed by the parent/guardian and physician at the time of examination and must be received by the camp office no later than 15 days prior to the camp session.**

\*\*\*A physician must personally examine all campers within 1 year of camp attendance date\*\*\*

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Temp: \_\_\_\_\_ Pulse: \_\_\_\_\_ Resp: \_\_\_\_\_ BP \_\_\_\_\_

Immunization Up-to-date: Yes: \_\_\_\_\_ /No: \_\_\_\_\_ Reason: \_\_\_\_\_

Date of Last Tetanus Booster: \_\_\_\_\_ **\*\*Attach copy of Immunization Record for Camper File\*\***

**PLEASE NOTIFY US IF CAMPER IS EXPOSED TO ANY COMMUNICABLE DISEASE OR HEAD LICE DURING THE THREE WEEKS IMMEDIATELY PRIOR TO CAMP ATTENDANCE.**

Diagnosis/Significant Health History: \_\_\_\_\_

Recent Illness/Hospitalization or Surgery, date and explanation: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Environmental Allergies: \_\_\_\_\_

Treatment for Allergic Reaction: \_\_\_\_\_

Seizure Activity: Yes \_\_\_\_\_ No \_\_\_\_\_ Date of last seizure: \_\_\_\_\_ Seizure type and frequency: \_\_\_\_\_

Diabetes: Yes \_\_\_\_\_ No \_\_\_\_\_ Type: \_\_\_\_\_ Treatment: \_\_\_\_\_

Asthma: Yes \_\_\_\_\_ No \_\_\_\_\_ Treatment: \_\_\_\_\_

Special instructions regarding activities the Camper cannot participate in or has limitations? \_\_\_\_\_

Any health or safety risk to self, or to other campers or staff? Explain: \_\_\_\_\_

**Medication Orders to be given by Camp Nurse (including prn, herbal, and over the counter):** Please print

	<b>Name of Medication:</b>	<b>Dosage:</b>	<b>Frequency:</b>	<b>Route:</b>
1				
2				
3				
4				
5				
6				
7				
8				

\*\*\*Camper is required to bring ample supply of all medications and any new prescriptions to camp. All medicines **MUST BE PRESCRIBED** and **in their original containers** (including vitamins and herbs) and will be administered according to the doctor's above written instructions. **If this page is not completed or there is no attached prescription, then medicine will not be administered by camp nurse.**

**(Must be completed by physician in its entirety)**

\* \* \* \* \*

I have examined \_\_\_\_\_, and reviewed his/her health history.  
(Camper's Name)

In my opinion this Camper is physically able to engage in camp activities, except as noted. Medications to be given by Camp Nurse as prescribed and directed above.

**EXAMINING PHYSICIAN:** \_\_\_\_\_  
(Please type or print name)

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
**Signature of Examining Physician** **Date**

THIS FORM MUST BE SIGNED & DATED BY PHYSICIAN WITHIN 1 YEAR OF CAMP ATTENDANCE

Name of Camper's Medical Insurance \_\_\_\_\_

Group Number: \_\_\_\_\_

**\*\*Attach a copy (front & back) of all current Insurance & prescription cards. \*\***