



CAMP PAHA
PERMISSION TO MEDICATE FORM

Name of Child \_\_\_\_\_ Age \_\_\_\_\_

Primary Health Care Provider \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_ Route \_\_\_\_\_

Purpose of Medication \_\_\_\_\_

Time of day medication is to be given \_\_\_\_\_

Possible Side Effects \_\_\_\_\_

Anticipated number of days to be given \_\_\_\_\_

Signature of Person with Prescriptive Authority

Date

Parent/Guardian

I hereby give my permission for \_\_\_\_\_ to take the above prescription or over-the-counter medication as authorized by the health care provider. I understand that it is my responsibility to furnish this medication.

Signature of Parent or Guardian

Date

Note: The medication is to be brought to the facility in its original container, appropriately labeled by the pharmacy or person with prescriptive authority.

You MUST have one form completed for each medication to be administered at Camp Paha.

Alternative formats of this document are available upon request.

Copy as needed.

**MEDICAL EXAMINATION:  
To be filled out by licensed health care provider.**

Camper's Name \_\_\_\_\_

DOB \_\_\_\_\_

**Purpose:** To determine participant's physical fitness to engage in camp activities. The requested information may be taken from a medical examination within the past 12 months.

Codes: V = Satisfactory    x= Not Satisfactory (explain)    o= Not Examined				
Height:	Weight:	Eyes:	Nose:	Throat:
Lungs:	Abdomen:	Hernia:	Spine:	Heart:
BP:	HCT/HGB:	Urinalysis:	Skin:	Extremities:
Allergies: (be specific to degree and reaction)				
Females: Has she menstruated?    If not, has she been told about menstrual periods? If so, is her menstrual history normal?				
Special considerations:		General Health Appraisal:		
<b>Health Care Recommendation by Licensed Medical Personnel</b>				

Date of last examination: \_\_\_\_\_

This camper is under the care of a physician for the following conditions: \_\_\_\_\_

Current treatment at the time of this report includes: \_\_\_\_\_

In my opinion, the above Camper    IS                      IS NOT able to participate in an active camp program.

**Recommendations and Restrictions at Camp**

Known allergies: \_\_\_\_\_

Description of any limitation or restriction on camp activities: \_\_\_\_\_

Additional information for health care staff at the camp: \_\_\_\_\_

**PHYSICIAN'S STATEMENT:**

I hereby request and give my permission for the City of Lakewood's Camp Paha to administer the medications prescribed and provide necessary treatment in an emergency. I have examined the person herein described within the past 12 months and have reviewed his/her health history. It is my opinion that this person is physically able to engage in Camp activities except as noted above:

Signature: \_\_\_\_\_, M.D. Telephone \_\_\_\_\_

Signature printed: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Address: \_\_\_\_\_ State \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Date Physical Form was Completed: \_\_\_\_\_

**IMMUNIZATION HISTORY:** Required immunizations are determined locally. You MUST provide a copy of your camper's complete up to date immunization record. Please complete the following or attach card or printout. Thanks.

Vaccine	Enter Date each immunization was given or attach card.				
DPT/ DtaP/diphtheria/ Pertussis /Tetanus					
DT (Diphtheria Tetanus)					
POV/IPV Polio					
Hib Haemophilus influenzae type b					
Measles					
Mumps					
Rubella					
HB - Hepatitis B					
Varicella – Chicken Pox					History of disease. Yes _____ Year _____