SOUTHCENTRAL CAMP MEDICAL PACKET
CHECKLIST/INSTRUCTIONS

Checklist for Parent/Guardian:

It is the responsibility of the parent/guardian to ensure this packet is completed in its entirety. Please ensure all forms are completed prior to submitting or enrollment in camp could be forfeited.

COMPLETION REQUIREMENTS PRIOR TO SUBMITTING:

□ Parent/Guardian had read through the entire packet.

□ Parent/Guardian has completed/signed/dated the top of Page 2 and top of Page 3

□ Cadet has read through the entire packet.

□ Cadet has signed Page 2 (under Parent/Guardian)

□ Physician has fully completed Pages 1-3.

□ Physician has signed/dated Pages 2 and 3.

□ Please include with your completed packet a copy (front and back) of the cadet's medical insurance card.

REQUIREMENTS PRIOR TO CAMP:

□ Prescription medications, vitamins, and over-the-counter medications/supplements are in ORIGINAL labeled containers with the correct amount for the week of camp (please double check and count).

□ Disclose any new conditions, ailments, allergies, injuries, medication changes, etc., to camp directors and medical staff.

Any questions or concerns regarding the completion of this packet can be directed to:
Trooper Kelly Smith, SouthCentral Camp Cadet Director, 717-249-2121, or email: smkell@pa.gov

SOUTHCENTRAL CAMP PREPARTICIPATION PHYSICAL EVALUATION – PART I

To be completed by a physician

Examining physician (MD, DO, NP, PA): The youth you are examining wishes to participate as a cadet in the SouthCentral Camp Cadet program. Please be advised the program is mentally and physically demanding and therefore he/she must be in good physical and mental health to participate. Your cooperation in conducting a thorough examination, as well as reporting pertinent information, is crucial and appreciated.

Cadet Name: ____________________________________ Date of Birth: ________________ Age: _______

Allergies (including dietary restrictions): ____

Height:	Weight:	Sex:
Blood Pressure:	Pulse:	
Vision: Right Eye 20/	Left Eye 20/	with correction? Yes / No

Medical	**Normal**	**Abnormal Findings**
Appearance: Marfan Stigmata (kyphoscoliosis, high-arched palate, pectus excavatu arachnodactyly, arm span> height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/Ears/Nose/Throat: PEARRLA, Hearing, etc.		
Lymph nodes		
Heart Murmurs (auscultation standing, supine, +/- Valsalva) Location of the point of maximal impulse (PMI) Pertinent history		
Pulses Bilateral femoral and radial		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin HSV, Lesions suggestive of MRSA, Tinea Corporis,etc		
Neurologic: Including ANY Behavioral/Psychiatric diagnosis or disorders? Please explain- include current treatment plan.		
Musculoskeletal		
Neck		
Back		
Shoulders/Arms		
Elbows/Forearms		
Wrists/Hands/Fingers		
Hips/Thighs		
Knees		
Legs/Ankles		
Feet/Toes		
Functional: Duck walk, Single Leg Hop, Push-Up		

SOUTHCENTRAL CAMP PREPARTICIPATION PHYSICAL EVALUATION – PART II

Cadet Name____ Date of Birth: ______________

We, the parent/guardian of the above-named cadet and I, the above-named cadet, swear by signing below, that all pertinent information has been disclosed to the physician signed on this document. We/I also acknowledge said cadet has no medical limitations that would prevent him/her from fully participating in SouthCentral Camp Cadet. We/I fully understand that in such event of non-disclosure of such condition(s), this application may be withdrawn and enrollment in SouthCentral Camp Cadet revoked.

Parent/Guardian Signature: __________________________________ Date: ____________________

Cadet Signature: ____ Date: ____________________

PHYSICIAN: Please answer the following (circle where appropriate)

1. Is the cadet up to date and current with immunizations? YES NO
   Date of last Tetanus booster ____________
2. Is this cadet, to the best of your knowledge, free from any communicable conditions, including but not limited to recent illnesses, skin conditions, etc? YES NO
   If answered "NO," please explain: ____
   ____
3. Is this cadet, to the best of your knowledge, free from behavioral/psychiatric conditions which would interfere with camp performance? YES NO
   If answered "NO," please explain: ____
   ____
4. Does this cadet have any conditions which the camp medical staff and/or counselors should be aware of? YES NO
   If answered "YES," please explain: ____
   ____
5. From this examination and from the cadet's health history, do you find this cadet physically and mentally fit to participate int his camp and all camp activities? YES NO

_____ Full clearance is granted without restriction to participate in SouthCentral Camp Cadet 2020

_____ This cadet is NOT cleared for participation

I have examined the above-named cadet and have completed the pre-participation physical evaluation to the best of my professional knowledge and ability. I will retain a copy of this evaluation for the cadet's record in my office. If any conditions arise after the cadet has been cleared for participation, the physician may rescind the clearance with appropriate notification made at that time to the SouthCentral Camp Cadet medical staff or administration, as well as to the cadet and their parent/guardian(s).

Signature of Examining Physician: ___________________________________ Date: _______________

Name (Please Print): ______________________________

Telephone: _______________________________________

Address: ____

____

SOUTHCENTRAL CAMP CADET MEDICATION/CARE PERMISSION FORM

All medications (prescription, over-the-counter, vitamins, etc.) MUST come to camp in the original container. No exceptions. Please only send the amount of medication that is necessary for the week.

Cadet Name: ____ Date of Birth: _______________ Age: _____

I authorize SouthCentral Camp Cadet medical staff or otherwise authorized staff to administer medication as instructed below to my child. I agree to deliver the medication in the original prescribed or over-the-counter container with pharmacy label, if applicable, to the medical staff on the date of arrival at camp. I will notify the camp medical staff if I change physicians or if the medication is changed or eliminated. I understand it is my child's responsibility to report on time for all medications. I fully release SouthCentral Camp Cadet, its entities, medical staff, and Board of Trustee from all liability to the administration of this medication and care.

In the event of an emergency, all efforts will be made to reach a parent or guardian. However, I give my permission to the medical staff, physician, and/or hospital selected by the camp administration, to hospitalize, secure proper treatment for, to order medications, injections, etc., in the best interest of my child.

Parent/Guardian Signature: ____

Name (Printed): ____ Date: ______________________

Phone during camp hours: __________________________ home/work/cell #2_____________________ home/work/cell

Emergency contact Name: ___________________________________ Relationship: ___________________

Phone during camp hours: __________________________ home/work/cell #2_____________________ home/work/cell

** TO BE COMPLETED BY PHYSICIAN/CLINICIAN**

Date of authorization: ___________________ Cadet Weight: ___________ lbs

Note: If dose not indicated below for over-the-counter medications, directions for age/weight provided on original package will be followed. □ CHECK HERE

□ Acetaminophen (ie. Tylenol Q 4-6 hours PRN-oral) ___ 325 mg ___ 500 mg ___650 mg ___ 1000 mg
□ Ibuprofen (ie. Motrin, Advil, Q 6-8 hours PRN-oral) ___ 200 mg ___ 400 mg ___600 mg ___ 800 mg
□ Calcium Carbonate (ie. Tums, Q 2 hours not to exceed 2 doses) ___ 500 mg ___ 750 mg ___1500 mg
□ Antihistamine (ie. Loratadine, Cetirizine) as directed on over-the-counter container for minor seasonal/environmental allergy symptoms.

First Aid Items: □ Triple Antibiotic Ointment (topical) for wounds □ Hydrocortisone cream (1%, topical) for itching □ Caladryl or Calamine (topical) for itching, insect bites, rash
□ Diphenhydramine HCL (ie. Benadryl): ___ 25 mg ___ 50 mg po Q _____ hours for minor allergic reactions

□ Epinephrine ________ mg, IM into outer thigh and call 911 for emergency treatment of severe, life threatening allergic reaction. MUST BE PROVIDED TO CAMP MEDICAL STAFF AT CHECK-IN (unexpired and clear solution).
□ Asthma inhaler: (name) ____________ - ____ puffs Q _____ PRN for wheezing, shortness of breath, cough
Please list all other medications the cadet currently takes with amount, dosage, frequency, times, and special instructions: ____

____

Physician Signature: ____ Date: ____________________

Name (Please Print): ____ Telephone: ________________