EMPOWER CAMP PHYSICIANS REPORT

This form must be completed by the camper's physician

Physician: ________________________________ Phone:___________________________

Street: __________________________Town: _______________State: _____Zip Code: _____________

Name of Empower Camp Participant:_____________________________________DOB:___/___/_____

Date of physical: ____/_____/______ (physical must be within past calendar year)

Patient's: HT _______ WT _______

Has participant been hospitalized within the past 3 years? _________________________

If yes, explain details and dates: ____

Immunization Records: Attach a copy of the participant's records of immunizations to this form.

Allergies: Does the participant have any allergies? Yes _____ No_____ If Yes, complete table below.

Allergy	Reaction	Treatment

If participant is required to carry an epi pen, participant must bring the epi pen and physician's RX. If the participant has a peanut or tree nut allergy, provide report from doctor describing participant's allergy.

Medications: List all medications (including over the counter or non-prescription drugs) being taken. Bring enough medication to last the entire time at camp. Medication must be in original packaging that identifies the medication, dosage and frequency of administration.

Medication	Dosage	Time Given	Reason	Special Instructions

Over the Counter Medication Authorization: I hereby authorize that the following medications may be given to the above named participant at Empower Camp after nursing assessment: **Bactine** (topical) for minor wound care, first aid as needed, **Triple Antibiotic Ointment** (topical) for wound healing, **Tylenol** (oral) as directed on bottle, **Ibuprophen** (oral) as directed on bottle, **Cough Drops** for coughing, minor throat irritation as needed, **Antacid Tablet** (oral) for stomach discomfort, **Benydryl** (oral or topical) for swelling, hives, and allergic reaction as directed on bottle, **Calamine Lotion or Cortaid** (topical) for insect bites/bee stings, **Visine/ Murine Plus Eye Drops** (topical in eye) for minor eye irritation or **Other** (please describe) ____________________________________

Physician Consent:

Physician Signature____Date__________________

Printed Name____________________________________ License Number_____________________