EMPOWER CAMP MEDICAL REPORT

TO BE COMPLETED BY THE PARTICIPANT'S PRIMARY CARE PROVIDER [PAGE 1 of 2]

Primary Care Provider: _____ Provider Phone:_____

Provider Address: _____ Town: _____ State: _____ Zip Code: _____

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

Date of physical: ____/_____/_____ (physical must be completed between July 29, 2021 and May 31, 2022)

Patient's: HT _____ WT _____ Patient's Blood Pressure: _____

Has participant been hospitalized within the past 3 years? □ Yes □ No

If yes, explain details and dates:

_____

_____

Is the participant currently undergoing medical treatment: □ Yes □ No

If yes, please explain:

_____

_____

Do you feel that the participant will require limitations or restrictions to activity while at camp? □ Yes □ No

If yes, please explain:

_____

_____

Immunization Records: *Provide the month and year for each immunization. All immunizations must be current. Copies of immunization records from health-care providers are preferred.*

Immunization	Month	Year
COVID-19		
Diptheria, tetanus, pertussis (DTaP) or (TdaP)		
Mumps, measles, rubella (MMR)		
Polio (IVP)		
Haemophilus influenza type B (HIB)		
Pneumococcal (PCV)		
Hepatitis A		
Hepatitis B		
Varicella (chicken pox)		
Meningococcal Meningitis (MCV4)		

Allergies: Does the participant have any allergies to food, medications or substances? 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.

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Name of Empower Camp Participant:_____ **DOB:**___/___/_____

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

Medication	Dosage	Time Given	Reason for medication	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 if needed and following nursing assessment:

Yes	No	Over the Counter Medication
		Acetaminophen (Tylenol)
		Ibuprophen (Advil, Motrin)
		Diphenhydramine (Benadryl) – oral or topical for swelling, hives, and/or allergic reaction as needed and directed by manufacturer
		Children's Cough Syrup (Robitussin)
		Throat Lozenges for sore throat as needed
		Pepto-Bismol for diarrhea
		Laxatives (Ex-Lax) for upset stomach or constipation
		Calamine Lotion (topical) for insect bites/bee stings
		Triple Antibiotic Ointment (topical) for wound healing
		Hydrocortisone 1% cream for mild skin irritations, poison ivy, and insect bites
		Sunblock/Sunscreen
		Aloe for sunburn
		Eye drops for minor eye irritation
		Antacid Tablet (tums) for stomach discomfort
		Other (list any other approved-over-the-counter medications) _____ _____

Provider Consent: "It is my opinion that the participant is physically and emotionally fit to participate in an active Empower Camp program (except as noted above.)"

Provider Signature_____Date_____

Printed Name_____ License Number_____