Camp Callahan INC.

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CAMP CALLAHAN PHYSICAL FORM

Name _____ Birthday____ /____ /____ Age _____

Address _____Zip _____

Home Phone _____ Cell Phone _____

Emergency Contact Person _____ Phone _____

Height _____ Weight _____ Blood Pressure _____

Allergies _____

_____

_____

Glasses ❑ YES ❑ NO

Does this camper use a breathing/oxygen machine at night? ❑ YES ❑ NO

Please check if the camper exhibits any problems with-or takes medication for any of the following:

- ❑ ADHD
- ❑ Asthma
- ❑ Diabetes
- ❑ Seizures
- ❑ Heart
- ❑ Cancer
- ❑ Fainting Spells
- ❑ Bleeding Disorder
- ❑ Sleepwalking
- ❑ Nervous Condition
- ❑ Depression
- ❑ COPD
- ❑ Bedwetting
- ❑ Incontinence (daytime)

Date of Last Tetanus Shot _____

Is there a need to restrict the camper's activities at camp? ❑ YES ❑ NO

Does the health officer have any concerns or comments regarding this person attending camp?

_____

Please indicate which of these over the counter medicines can be given to the camper without additional consent beyond this form.

- ❑ Acetaminophen (Tylenol)
- ❑ Anti-Diarrhea tablets or liquid
- ❑ Antibacterial cream (Neosporin)
- ❑ Chaffing Gel/Powder/Spray
- ❑ Ibuprofen (Advil)
- ❑ Antacids (Tums)
- ❑ Eye Drops (Visine)
- ❑ Sunburn Relief Spray or Lotion
- ❑ Antihistamine Tablet or Liquid
- ❑ Antihistamine Cream (bug bites/poisen Ivy
- ❑ Swimmer Ear Relief Drops
- ❑ Upset Stomach Relief (Pepto)

Doctor/Health Officer Signature _____ Date _____