

PHYSICAL EXAM FORM

****Complete when camper has been approved****

www.horizonsct.org -forms available on our website

Horizons, Inc.

P. O. Box 323 South Windham, CT 06266

860-456-1032 fax: 860-456-4721

DATE OF PHYSICAL MUST BE WITHIN TWO YEARS OF ATTENDANCE

Camper's Name: _____ DOB: _____ Age: _____

Address: _____
(Street) (City, State) (Zip Code)

Medical Classification(s)/diagnosis _____

Significant past Medical History (including physical handicaps) _____

Is the camper taking any prescribed medications? Yes _____ No _____ (If yes, please complete front of ivory medication form.)

Is the camper using any over-the-counter medications? Yes _____ No _____ (If yes, please complete back of ivory medication form.)

Is this person subject to seizures? Yes _____ No _____ If yes, date of last seizure _____

Please describe seizures: When do they occur? _____ for how long? _____ how frequently? _____

When should parent/provider/physician be notified of seizure activity: after every seizure _____ after seizure lasting _____

Medication allergies? _____ If yes, list: _____

Other allergies? _____ If yes, list: _____

Can this person participate in the following activities (in agreement with guardian and health history)

-Swimming? Yes _____ No _____ (Lifeguard is provided)

-Row-boating? Yes _____ No _____ (Lifejacket & lifeguards are provided)

Does this person need special considerations beyond general supervision within a 1:5 ratio during swimming, boating, or any other activity? Yes _____ No _____ If yes, please explain _____

Please list any medical concerns or treatments to be monitored at camp:

Please describe any condition requiring immediate notification of parent/provider/physician:

Please describe any medically prescribed meal plan or dietary restrictions, including substitute foods:

Are there any other chronic medical conditions not mentioned above that our nursing staff and/or direct care staff should be aware of including but not limited to atlantoaxial instability, communicable disease, etc.: _____

MEDICAL REPORT FORM (cont.) NAME _____ DOB _____

Immunization History Required immunizations must be determined locally.

Please record the date of basic immunizations and most recent booster doses or attach immunization records.

Vaccines	Year of Basic Immunization	Year of Last Booster
DPT		
TD		
TETANUS		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Tuberculin test given _____ (most recent)		
Haemophilus Influenza B (HIB)		
Hepatitis B		
Varicella (Chicken Pox)		
Other		

COVID-19 VACCINE	
Date of 1 st dose	
Date of 2 nd dose	



Date of Physical Exam: _____

I certify that I have completed a physical examination of this person within the last two years on the date listed above. This person is in satisfactory condition to participate/work in an active residential camping program for and with people who have developmental disabilities. I am aware of all medications prescribed to this camper and see no contra-indications.

If camper should not receive one or more of the listed items, indicate by crossing through: (e.g. ~~Benadryl~~) This person may receive over-the-counter PRN medications and/or treatments in accordance with Camp Horizons' standing orders as deemed necessary by infirmiry staff and as permitted by absence of any known allergy.

Medication	Form		Medication	Form
Acetaminophen	Liquid/tablets		Immodium	Liquid/tablets
Aloe			Maalox	
Aspirin	Liquid/tablets		Midol	
Bacitracin cream			Milk of Magnesia	
Benadryl	Liquid/capsules		Mylanta	
Calamine or Caladryl lotion			Robitussin DM	
Calmoseptine (Barrier Cream)			Saline rinse	
Cough drops			Senakot	Liquid/tablets
Epinephrine (For Emergency Only)			Sudafed	
Hydrocortisone cream			Tinactin	
Ibuprofen	Liquid/tablets		Tums	

PHYSICIAN/PRIMARY CARE PROVIDER'S SIGNATURE:

PHYSICIAN'S/PCP'S NAME PRINTED

ADDRESS

PHONE NUMBER