Annual Physical Form

Please return completed form to:
Akron Rotary Camp
4460 Rex Lake Drive
Akron, OH 44319
(330) 644-1013 (Fax)
rotarycamp@akronymca.org (email)

Questions? Comments?
Please cont act us at :
(330) 644-4512
gotcamp.org

The following non-prescription medications are stocked in the Health Lodge and used on an as needed basis to manage illness and injury.

Please CROSS OUT those items the camper SHOULD NOT be given.

Acetaminophen (Tylenol)
Aloe Gel
Bacitracin antibiotic cream
Betadine
Calamine lotion
Diphenhydramine (Benadryl)
Diphenhydramine (Benadryl) cream
Generic cough drops
Ibuprofen (Motrin)
Milk of Magnesia
Tums

This camper is undergoing treatment for the following condition(s):

___ None

___ Yes (please describe):

Diet /Nutrition:

___ Eats a regular diet

___ Has a medically prescribed diet (please describe):

Other treatment /therapies to be continued at camp:

___ None

___ Yes (please describe):

Camper's Name _____

Date of Birth _____

Physical Date _____ Height _____ Weight _____

Allergies _____

Medications

___ No daily medications

___ Will take the following prescribed medications

	Name of Medication	Dosage	Times/Meals
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			
i.			
j.			

Please provide a list of medications if additional room is needed.

Please describe any limitations or restrictions that the camper may have while at camp:

I have discussed the camp program with the camper's parent(s)/Guardian(s). It is my opinion that the camper is physically and emotionally fit to participate in an active camp program (except as noted above).

Name of licensed provider - MD, DO, PA or APRN (please print): _____

Signature _____ Title _____
Must be signed by a non-household member.

Office Address _____
Street City State Zip Code

Telephone _____ Date _____