## **CAMP NEW DAWN II HEALTH EXAMINATION FORM**

RETURN TO: Butman Camp Registrar 158 CR 674 Merkel, TX 79536

Please have parent/guardian and physician complete appropriate sections of this form <u>in full</u> before mailing. The following information is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. **Everything must be completely filled out or form will be returned.** 

Camper Name:				Date: _			
	RECOMMENDATIO  *This section must I	_	_		_		
Is camper on a special of	liet?	Yes	No	Explain			
		Yes	No	Explain			
Is camper on any new m	Yes _	No	Explain				
Is medicine being sent by parent/guardian?		Yes _	No	Explain			
Restrictions on swimmin	g, diving?	Yes	No	Explain			
Restrictions on strenuou	Restrictions on strenuous activity?		No	Explain			
Is camper able to dress	self?	Yes _	No	Explain			
Is camper able to sleep in an upper bunk?		Yes	No	Explain			
Is camper able to talk?		Yes	No	Explain			
Does camper walk well?		Yes	No	Explain			
ls camper an early riser?		Yes	No	Explain			
Does camper wet the bed?		Yes	No	Explain			
Does camper smoke or chew tobacco?		Yes	No	Explain	in		
Is camper able to read?		Yes	No	Explain			
Does camper have incontinence problems?		Yes	No	Explain			
Is camper a sleepwalker?		Yes	No	Explain			
Does camper wear prote	ective garments (i.e. Dep	ends)	Yes	No Explair	າ		
Campers T-Shirt Size Other	S M L XL XXI	-					
T	otally Independent	Par	tially Ind	ependent	Dependent		
Brush Teeth Bathing							
Dressing							
Eating Toilet Usage							
Tollet Osage							

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **MEDICAL EXAMINATION**

## To be filled out by licensed physician

This examination should be performed within 12 months before arrival at camp. You may attach a current physical (if it occurred in the last 12 months) as long as it contains the same information as below. Examinations are necessary for determining fitness/ability to engage in all activities.

			ND HAVE REVIEWED HIS/HE		
Comments					
Commentar					
Special conside	erations:				
If so, is her me	nstrual history normal?				
* (For girls and	women) Has this person	menstruated?	If not, has she been to	ld about it	?
Hernia					
Abdomen					
Lungs			General Appraisal:		
Throat					
			Skin		
Eyes			Extremities		

## **Butman Methodist Camp**

<b>Camper Medic</b>	ation Form for:	(Camper's Name)
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Please Note: All prescription medications must be in the original prescription containers with Camper's name and dosage clearly marked on the container.

Camper can not stay if not followed. Please put dosage and at what time to give. Important: Insulin dosages must be included and must be clearly readable. Make sure the medication name matches what is on the bottle

Sure the medication name matches what is on the bottle							
Medication Name/mg	Dosage	Before Breakfast	Breakfast	Lunch	Afternoon	Dinner	Evening
EXAMPLE: BENADRYL	12mg	1 tab					2 tabs
EXAMPLE: TYLENOL	10mg	AS NEEDED					