



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 contact 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

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:

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):

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 licenced provider (please print): _____

Signature _____ Title _____

Office Address _____
Street City State Zip Code

Telephone _____ Date _____