The Achievement Centers for Children
Recreation Department
Physical Exam Report

Medical Personnel

This document is to be completed by a Physician, Advanced Practice Nurse (APN), or Nurse Practitioner (NP).
Attach additional information if needed.

Participant Name: ____ **Date of Birth:** _______________
(Month/Date/Year)

Date of most recent physical exam (Must be within the last 12 months): _______________
(Month/Date/Year)

Section 1: Allergies (Attach additional page if needed)

Allergic to: Include foods, medications, environmental, animals, etc.	**Symptoms Associated**
1.	
2.	
3.	
4.	
5.	

Section 2: Seizure History and Seizure Action Plan

Does the participant have a history of seizures? ☐ No (Move to Section 3) ☐ Yes – Date of last seizure: _______________
(Month/Date/Year)

Complete for participants with seizure activity in the last 10 years:

Seizure Type(s)	How long it lasts	How often/Frequency	Triggers/Aura	What happens/What seizure looks like

Check boxes that apply to Seizure Action Plan:

☐ Staff will remain calm, assess the participant, and begin timing the seizure. They will keep the participant safe by: removing any nearby potentially harmful objects, not restraining the participant, and protecting the participant's head. If the participant is not awake, they will turn them on their side and keep their airway clear. They will NOT insert any objects into the participant's mouth.

☐ Applicable IF participant has a VNS – must include VNS in Section 5: Medical Treatments: Certified staff will swipe magnet for VNS.

☐ Staff will call 911 ________ minutes after seizure has begun.

☐ Applicable only IF medication is listed in Section 4: Prescription Medications and is available to participant during programming:
Certified staff will administer prescribed emergency seizure medication ________ minutes after seizure has begun.
Certified staff will administer prescribed emergency seizure medication if ____ or more seizures occur within _______ [timeframe].
If seizure has not stopped within _______ minutes after seizure medication is administered, staff will call 911.

☐ Other: ____
____

Additional comments:

Section 3: Over-the-Counter Medications

Below is a list of over-the-counter medications available to participants within the River Rock Adult Day Program and Camp Programs on an “as needed” basis (PRN). Information includes medication name, strength, recommended child and adult dose, route, frequency, and reason for administering the medication. We may stock name brand or generic.

Medication	Route	Adult Dose	Child Dose	Frequency	Reason	Permission to Administer?
Sunscreen	Topical	Apply to skin in accordance with manufacturer’s label/ instructions.	Apply to skin in accordance with manufacturer’s label/instructions.	Every 2 hours as needed.	To help protect skin from sunburn	☐ **YES,** the participant has my permission to take this medication, as needed. ☐ **NO**, the participant does NOT have my permission to take this medication.
Bug Spray/Insect Repellant	Topical	Apply to skin in accordance with manufacturer’s label/ instructions.	Apply to skin in accordance with manufacturer’s label/instructions.	Every 4 hours as needed	To aid in the prevention of insect bites	☐ **YES,** the participant has my permission to take this medication, as needed. ☐ **NO**, the participant does NOT have my permission to take this medication.
Hydrocortisone 0.5% cream/ointment	Topical	Apply to skin with gloved hand in accordance with manufacturer’s label/ instructions.	Apply to skin with gloved hand in accordance with manufacturer’s label/instructions.	Every 6 hours as needed. Do not exceed 4 doses in a 24 hour period	To provide temporary relief of (1) minor skin irritation, itching, and rashes caused by eczema, insect bites, poison ivy, poison oak, poison sumac, soaps, detergents, cosmetics, & jewelry; (2) itchy anal/rectal areas; and 3) itching/ irritation of the scalp	☐ **YES,** the participant has my permission to take this medication, as needed. ☐ **NO**, the participant does NOT have my permission to take this medication.
Bacitracin zinc 500-units; Neomycin sulfate 3.5mg; Polymyxin B sulfate 10,000 units; Pramoxine HCl 10mg (First Aid Antibiotic Pain Relieving Ointment)	Topical	Apply to skin with gloved hand in accordance with manufacturer’s label/ instructions.	Apply to skin with gloved hand in accordance with the manufacturer’s label/instructions.	Every 8 hours as needed. Do not exceed 3 doses in a 24 hour period	To treat and prevent infection due to minor cuts, scrapes, and burns	☐ **YES,** the participant has my permission to take this medication, as needed. ☐ **NO**, the participant does NOT have my permission to take this medication.
Diphenhydramine HCl (Benadryl), 12.5mg/5mL	Oral	Adult/Children 12+ years old = 10mL oral solution (25mg)	2-5 years = Do not use 6-11 years old = 5mL oral solution (12.5mg)	Every 4 hours as needed. Do not exceed 6 doses in a 24 hour period	To temporarily relieve symptoms due to hay fever or other upper respiratory allergies: sneezing, itching of the nose or throat, runny nose, itchy/watery eyes	☐ **YES,** the participant has my permission to take this medication, as needed. ☐ **NO**, the participant does NOT have my permission to take this medication.
Acetaminophen	Oral	One 325-mg tablet or capsule	Children's Suspension Liquid (160mg/5mL) 24-35 lbs.= 5mL 36-47 lbs.= 7.5mL 48-59 lbs.= 10mL 60-71 lbs.= 12.5mL 72-95 lbs.= 15mL	**Adult:** Every 4 hours as needed. Do not exceed 3,000 mg in a 24 hr. period **Child:** Every 4 hours as needed. Do not exceed 5 doses in a 24 hr. period	For complaint of headache, toothache, muscle aches, menstrual cramps, aches/pains of cold or flu, or fever of 100°F or above	Per the Ohio Dept. of Developmental Disabilities Medication Admin. rule– **CHECK ONLY ONE BOX** ☐ **YES,** the participant has my permission to take **ACETAMINOPHEN** as described. ☐ **YES,** the participant has my permission to take **IBUPROFEN** as described. ☐ **NO**, the participant does NOT have my permission to take **EITHER** of these medications as described.
Ibuprofen	Oral	One 200-mg tablet or capsule	Liquid suspension (100mg/5mL) 36-47 lbs.= 7.5mL 48-59 lbs.= 10 mL 60-71 lbs.= 12.5mL 72-95 lbs. = 15 mL	Every 6 hours as needed. Do not exceed 4 doses in a 24 hour period. Take with food.		

Section 4: Prescription Medications

Is the participant taking any medications- including over-the-counter, prescription, PRN, or emergency?

☐ **No** (Move to Section 5)   ☐ **Yes** – Complete table below for each medication. Attach additional page(s) if needed. You may attach a printed medication list such as MyChart, if preferred, provided all the required elements are included.

	Medication Name and Strength (e.g. Ibuprofen 200 mg)	**Route** (Oral, topical, intranasal, etc.)	**Type of medication** (Tablet, solution, cream, etc.)	**Dose** Note: Dosage must be an exact amount (e.g. not "1-2 tablets")	**Frequency/Time of Administration** Note: For daily medications to be administered during programming, an EXACT TIME must be listed (e.g. 12:00 p.m. not "at lunch")	**Additional Comments/Instructions** Note: For PRN medications to be administered during programming, order must include the specific reason for administration (e.g. "for cough lasting longer than 15 minutes") **Participants are responsible for bringing their own medications to camp, including PRNs.**
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Section 5: Medical Treatments

Is the participant currently undergoing any medical treatments? ☐ No ☐ Yes – Describe below

____

____

Will the participant need to undergo any medical treatments during programming? ☐ No ☐ Yes – Describe below

____

____

____

Section 6: For Persons with Down Syndrome Only

Upon an examination, this individual ☐ did not ☐ did reveal atlantoaxial instability or focal neurological disorder.

Section 7: Any additional comments regarding the participant's medical care/needs? Please describe below.

____

____

____

____

____

____

____

____

____

Based on the above knowledge, I certify this individual is:

☐ **ABLE TO PARTICIPATE**: I certify, to my knowledge that this person **can** participate within the programs at Camp Cheerful. However, I understand that the Achievement Centers for Children will weigh the medical information above against the existing precautions and contraindications.

☐ **UNABLE TO PARTICIPATE**: I certify, to my knowledge that this person **cannot** participate within the programs at Camp Cheerful.

Signature of Licensed Provider: ______________________________________ **Date (required):** __________________

Name of Licensed Provider (please print): ____

Address: ____

Phone: ____