PHYSICAL AND HEALTH RECORD

RETURN THIS FORM TO CBX

PHYSICAL EXAMINATION

Every camper is required to have a physical completed by a medical professional and dated within 2 yearsof the end date of his/her camp. Cross Bar X keeps camper physicals on file for at least two years. If you think we have a current physical on file, please contact us to confirm that we do have one on file. If we do not have a current physical on file, have your medical personnel fill out and sign this form. If your doctor uses a separate form, make sure the information asked for below is included on that form.

VACCINATION RECORD

Must be filled out annually. A Colorado Certificate of Immunization is attached at the end of this section.

Camper Name: **Gender:** M F **Age:** **Height:** **Weight:**

CAMPER'S OVERALL HEALTH

Good **Fair** **Special conditions (please list below)**

List any physical, psychological, or other concerns that may effect this child's ability to participate in camp:

Special diet or food intolerances:

Circle all that pertain to this camper: asthma diabetes frequent ear infections headaches seizures diarrhea constipation bed-wetting sleepwalking other:

List any other concerns:

MEDICATION LIST (If none, write N/A)

MEDICATION POLICY: If your child will be taking medications at the time of camp, it is important that you adhere to following policy: ALL medications MUST be turned into the camp nurse at the time of check-in. By state regulations, campers cannot keep any medications with them (with exception to some inhalers). The camp nurse will make sure the camper takes the prescribed dosages at the proper times.

Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician, the name of the medication, dosage, and the frequency of administration. Do not put pills in baggies/pill boxes. We must give the dosages as prescribed. If the dosage has been changed, make sure you bring a written doctor's prescription that gives the adjusted dosage. List all medications, including over-the-counter, that the camper will be taking at the time of camp. If your child will not take medications, write N/A on the first line.

Medication	Purpose	Dosage	Time of Day

Allergiies & Medical History

List any food allergies:

List any envrionmental allergies:

List any allergies to medications:

Other allergies or pertinent medical history:

The following nonprescription medications may be stocked in the camp health center and administered by certified Cross Bar X Staff members as needed to manage illness and injury. **Cross out those the camper should NOT be given:**

Allergy Eye Drops
Benadryl (diphenhydramine)
Caladryl Lotion (relieves itching)
Claritin
Cough Drops
Topical Lidocaine 2% (anesthetic)
Triple Antibiotic Ointment
Tylenol (acetaminophen)
Tums
Vitamin C Chewable Tablets
Hydrocortisone Cream
Hydrogen Peroxide
Ibuprophen
Immodium AD (anti-diarrheal)
Maalox
Dulcolax (laxative)
Epinephrine (in case of a lifethreatening allergic reaction)
Milk of Magnesia
Simethicone (gas relief)

EXAMINER (Physician, physician's assistant, or nurse practitioner)

Print Name: **Title:** **Date:**

Signature: **Clinic/ Hospital:**

Address: **Phone:**

Parent/Guardian Signature: **Date:**

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https://www.crossbarx.org
theranch@crossbarx.org

COLORADO CERTIFICATE OF IMMUNIZATION

www.coloradoimmunizations.com

COLORADO
Department of Public Health & Environment

This form is to be completed by a health care provider (physician (MD, DO), advanced practice nurse (APN) or delegated physician's assistant (PA)) or school health authority. School required immunizations follow the ACIP schedule. Note: Final doses of DTaP, IPV, MMR and Varicella are required prior to kindergarten entry. Tdap is required at 6th grade entry.

Student Name: ..... **Date of birth:** .....

Parent/guardian: .....

Required vaccines

	Immunization date(s) MM/DD/YY						**Titer date*** MM/DD/YY
Hep B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis (pediatric)							
Tdap Tetanus, Diphtheria, Pertussis							
Td Tetanus, Diphtheria							
Hib *Haemophilus influenzae* type b							
IPV/OPV Polio							
PCV Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella							
Measles							
Mumps							
Rubella							
Varicella Chickenpox							

Varicella - date of disease		**Varicella** – positive screen date	

*A positive laboratory titer report must be provided to the school to document immunity.

*The shaded area under "Titer date" indicates that a titer is not acceptable proof of immunity for this vaccine.

Recommended vaccines

	Immunization date(s) MM/DD/YY						
HPV Human Papillomavirus							
Rota Rotavirus							
MCV4/MPSV4 Meningococcal							
Men B Meningococcal							
Hep A Hepatitis A							
Flu Influenza							
Other							

Health care provider signature or stamp: ..... Date: .....

Student is current on required immunizations for age (circle one): Yes No

OR

Immunization record transcribed/reviewed by school health authority:

School health authority signature or stamp: ..... Date: .....

Statement of Exemption to Immunization Law

Medical Exemption: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

SIGNED: **(Physician)** **Date:**

Religious or Personal Exemption: Parent or Guardian of the above named person or the person himself/herself is an adherent to a religious belief or is personally opposed to immunizations.

SIGNED: **(Parent/ Guardian, emancipated student/consenting minor)** **Date:**