



73 East Valley Brook Road  
Long Valley, New Jersey 07853  
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## STAFF EXAMINATION FORM

**Must be completed by a physician based on a Physical Exam performed on or after 8/17/10.  
Please Mail this form back to Meadowbrook by April 30, 2012.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

The above named individual was examined in my office on this date: \_\_\_\_\_

BP: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

In my opinion, this individual  is  is not able to participate in an active program.

This individual is under my care for the following condition(s): \_\_\_\_\_  
\_\_\_\_\_

### **MEDICATION**

The above named individual takes the following medication during the winter and/or during the summer  
(please be specific): \_\_\_\_\_  
\_\_\_\_\_

### **ALLERGIES**

Known Allergies:

Food(s) \_\_\_\_\_ Reaction \_\_\_\_\_

Medicine(s) \_\_\_\_\_ Reaction \_\_\_\_\_

Other \_\_\_\_\_ Reaction \_\_\_\_\_

**NOTE: Allergy Action Plan Form MUST be submitted for the administration of medication.**

Physician's Name \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

Physician's Phone # \_\_\_\_\_

Physician's Address \_\_\_\_\_  
\_\_\_\_\_

Physician Office Stamp

Staff Member Signature \_\_\_\_\_ Date \_\_\_\_\_

(to be signed by a parent or guardian if staff member is under 18 yrs of age)

**PLEASE COMPLETE THE REVERSE SIDE FOR IMMUNIZATION RECORDS AND  
AUTHORIZATION FOR NON-PRESCRIPTION MEDICATIONS**

<b><u>IMMUNIZATION HISTORY</u></b>	Dose 1 Mo/Yr	Dose 2 Mo/Yr	Dose 3 Mo/Yr	Dose 4 Mo/Yr	Dose 5 Mo/Yr	Most Recent Dose Mo/Yr
DPT						
dT or Tdap						
Prevnar (PCV7)						
MMR						
or						
Mumps						
Measles						
Rubella						
Polio (IPV)						
HIB						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)						
Meningococcal						

**AUTHORIZATION FOR NON-PRESCRIPTION MEDICATIONS**

In the event of a minor medical emergency or illness, the Camp Nurse has my permission to administer the following over-the-counter medications according to the label instructions, at her discretion:

(Please circle)

- |   |     |    |
|---|-----|----|
| <b>Acetaminophen (Tylenol)</b> for discomfort, pain, fever                      | Yes | No |
| <b>Cepacol lozenges</b> for sore throat   | Yes | No |
| <b>Cortisone Cream/Ointment</b> for skin rash on unbroken skin, insect bites    | Yes | No |
| <b>Cough Drops</b> for irritated throat or cough                                | Yes | No |
| <b>Diphenhydramine (Benadryl)</b> for allergic reactions, hives, severe itching | Yes | No |
| <b>Ibuprofen (Advil/Motrin)</b> for discomfort, pain, fever                     | Yes | No |
| <b>Medicaine</b> for bee stings   | Yes | No |
| <b>Midol/Pamprin</b> for menstrual pain (if applicable)                         | Yes | No |
| <b>Orajel</b> for toothache, dental pain  | Yes | No |
| <b>Triple Antibiotic Ointment (Neosporin)</b> for minor wounds                  | Yes | No |
| <b>Tums / Pepto Bismol</b> for upset stomach                                    | Yes | No |
| <b>Zanfel</b> for poison ivy  | Yes | No |

**PLEASE COMPLETE THE REVERSE SIDE FOR EXAMINATION INFORMATION AND SIGNATURES OF PHYSICIAN AND STAFF MEMBER**