SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Children and Youth with Special Health Care Needs

Camp Burnt Gin Medical Examination

Applicant's Name:	**Date of Birth:**

Pages 1 and 2 must be completed by a licensed physician, advanced practice nurse (APRN), or physician assistant for all Camp Burnt Gin applicants. ***Physical examination must be completed within 12 months of applicant attending camp.***

Immunizations are up to date: ☐ NO ☐ YES *(Attach copy of SC Immunization certificate.)*	**Date of Exam:**

Diagnoses (List ALL medical diagnoses, health conditions, or disabilities.)

1.	5.
2.	6.
3.	7.
4.	8.

For applicants with a seizure diagnosis, complete the Camp Burnt Gin Acute Seizure Action Plan, Form 4522.

Allergies: ☐ NO ☐ YES *(If yes, please list below.)*

Height:	**Weight:**	**Blood Pressure:**	**Respiratory Rate:**	**Pulse Oximetry:**	**Heart Rate:**	**Temperature:**

Exam Findings	**WNL**	**ABN**	**Explain Abnormal/Unusual Findings**
Skin	☐	☐	
Head/Neck	☐	☐	
Eyes	☐	☐	
Ears	☐	☐	
Nose	☐	☐	
Mouth/Throat	☐	☐	
Chest/Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	

General Appraisal:

Special Diet: ☐ NO ☐ YES *(if YES, describe below. Include prescribed formula, if applicable.)*

Does applicant have a G-tube?

☐ NO ☐ YES *(if YES, complete the Camp Burnt Gin Enteral/Gastronomy Feeding Action Plan, 4515-ENG-DPH.)*

Medications: ☐ NO ☐ YES *(if YES, list name, dose, frequency, and route, or attach list. Camp staff will not administer vitamins or herbal supplements.)*

Treatments: ☐ NO ☐ YES *(if YES, describe below. Include orders for catheterization, if applicable.)*

Does the applicant use a CPAP or BiPAP machine?

☐ NO ☐ YES *(if YES, complete the Camp Burnt Gin CPAP/BiPAP Waiver, Form 1856.)*

May the applicant participate in the swimming program?

☐ NO ☐ YES

Limitations or restrictions on camp activities:

Medical and/or social problems that camp staff should observe and report:

I have examined the person herein described and have reviewed their health history. It is my opinion that they are physically able to engage in camp activities, except as noted above.

Signature and Credentials:		**Date:**
Name (PRINT)**:**	**Phone Number:**	**Fax Number:**
Address:		

Physician to contact if there is a problem at camp:

Name:	**Phone Number:**	**Fax Number:**

Primary Care Physician:

Name:	**Phone Number:**	**Fax Number:**

Camp Burnt Gin Medical Examination

Instructions for Completing 4523-ENG-DPH

PURPOSE

This form is completed by the licensed physician, advanced practice nurse (APRN), or physician assistant (PA) to provide information about prospective campers to determine if they can be safely cared for in a residential camp setting, and to provide information for applicants' care while at camp.

AUDIENCE

The licensed physician, advanced practice nurse (APRN), or physician assistant (PA) completes the Camp Burnt Gin Medical Examination.

OFFICE MECHANICS & FILING

The enrollment application is kept in the applicant's file at camp during the summer and becomes part of the permanent file maintained by the Children and Youth with Special Health Care Needs Section for 13 years after the minor's last Camp session, or until the minor has reached his/her nineteenth birthday whichever period is longer.