**Camp Rising Sun**
**PO Box 472**
**Branford, CT 06405**
www.camprisingsun.com

**Return Medical Form:**
registration@camprisingsun.com
**Fax: 203-654-7886**
(or mail to PO Box)

# CAMP RISING SUN – STAFF PHYSICAL FORM

*(This page is to be completed by the CRS staff member)*

Staff Member Name: ___________________________________ Date of Birth: ______________

Address: _________________________________________ City:_________________State:_________ Zip:___________

**Please indicate any of the following (please explain if appropriate):**

- Neurological Problems (i.e. seizures) □ No □ Yes: ___________________________________
- Respiratory Problems □ No □ Yes: ___________________________________
- Cardiac Problems □ No □ Yes: ___________________________________
- Gastrointestinal Problems □ No □ Yes: ___________________________________
- Genitourinary Problems □ No □ Yes: ___________________________________
- Muscular Problems □ No □ Yes: ___________________________________
- Vision Problems □ No □ Yes: ___________________________________
- Hearing Problems □ No □ Yes: ___________________________________
- Skin Problems or Rashes □ No □ Yes: ___________________________________
- Allergies (including foods, medications, insect stings & hay fever) □ No □ Yes: ___________________________________ ________________________________________________

**Immunization History:** State requirement for camp. Information must be kept up to date.

*Ok to provide immunization records in place of completing. Indicate "NA" where not applicable.*

- **COVID-19** (date) 1st Dose:_______________ 2nd Dose:_______________ 3rd Dose:______________

| | | | |
|---|---|---|---|
| ▪ **Tetanus Booster*** | Date: _________________ | ▪ **MMR*** | Date: _________________ |
| ▪ DPT Series | Date: _________________ | ▪ Polio | Date: _________________ |
| ▪ Hepatitis A | Date: _________________ | ▪ Pneumococcal | Date: _________________ |
| ▪ Hepatitis B | Date: _________________ | ▪ Rotavirus | Date: _________________ |
| ▪ Hib | Date: _________________ | ▪ Tuberculin Test | Date: _________________ |
| ▪ Influenza | Date: _________________ | ▪ Varicella/chicken pox date | Date: _________________ |
| ▪ Meningococcal | Date: _________________ | ▪ Other | Date: _________________ |

*Proof of measles vaccine must accompany this health form. Please fill in actual dates. Do not check or fill in with "up to date". Tetanus must be within the past 10 years.

**Any recent or current infectious/communicable disease exposure?** □ No □ Yes: ___________________________________

Do you have any of the following restrictions? Explain if appropriate:

- Diet □ No □ Yes: ___________________________________
- Swimming or Water Sports □ No □ Yes: ___________________________________
- Climbing □ No □ Yes: ___________________________________
- Strenuous Activity □ No □ Yes: ___________________________________
- Contact Sports □ No □ Yes: ___________________________________
- Special Equipment (Glasses, Prosthesis Crutches, etc.) □ No □ Yes: ___________________________________

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# CAMP RISING SUN – STAFF PHYSICAL FORM

*(This page is to be completed by a licensed physician)*

**Date of Physical:** ______________________ **Physicals must be completed within 2 years of Camp

Patient Name: _______________________________________ Date of Birth: ___________

Height: ______________ Weight: _________________ ☐ Male ☐ Female

▪ Are medications needed at Camp? ☐ Yes ☐ No

| Medication | Strength | Dosage | Form | Frequency |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

▪ Comments, including condition(s) for which medication(s) are being administered: ______________________
_______________________________________________________________________________

▪ The applicant is under the care of a physician for the following conditions: ___________________________
_______________________________________________________________________________

▪ Explanation of any reported loss of consciousness, convulsions or concussion: _________________________
_______________________________________________________________________________

▪ Additional Health Information: __________________________________________________________
_______________________________________________________________________________

▪ Might any of the prescribed medicine(s) above impair his/her ability to perform the essential functions of the position? ☐ Yes ☐ No

*****I have examined the above-named person on ________________ (date of examination) and have determined that in my opinion, his/her medical and mental health history allows participation in an active camp program**: ☐ Yes ☐ No

**Physician's Signature**: ___________________________ **Date**: _____________________________

**Street Address**: _______________________________ **City/State/Zip**: _____________________

**Phone #**: ___________________________________ **State of Licensure**: ___________________

**Please return this completed Medical Form:**
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**MEDICATIONS MUST BE BROUGHT IN THEIR ORIGINAL PHARMACY CONTAINERS**