



## 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)                               | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Respiratory Problems  | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Cardiac Problems  | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Gastrointestinal Problems   | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Genitourinary Problems  | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Muscular Problems   | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Vision Problems   | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Hearing Problems  | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Skin Problems or Rashes   | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Allergies (including foods, medications, insect stings & hay fever) | <input type="checkbox"/> No | <input type="checkbox"/> 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.*

***At this time we believe COVID-19 testing will be required prior to camp week. We are unsure about vaccination requirements but strongly encourage all staff to be vaccinated to protect our campers.***

- |                    |             |  |             |
|--------------------|-------------|--|-------------|
| ▪ COVID-19         | Date: _____ | 2 <sup>nd</sup> Dose Date (if applicable): _____ |             |
| ▪ 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   | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Swimming or Water Sports                               | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Climbing   | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Strenuous Activity                                     | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Contact Sports   | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |
| ▪ Special Equipment (Glasses, Prosthesis Crutches, etc.) | <input type="checkbox"/> No | <input type="checkbox"/> Yes: _____ |



## 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:

Email: [registration@camprisingsun.com](mailto:registration@camprisingsun.com) – Fax: (203) 654-7886 – P.O. Box 472; Branford, CT 06405

**MEDICATIONS MUST BE BROUGHT IN THEIR ORIGINAL PHARMACY CONTAINERS**