MEDICAL EXAMINATION

Give this form, along with the HEALTH HISTORY and MEDICATION forms in this packet, to your health care provider for review and signature. This form must be singed by your licensed physician or licensed nurse practitioner within 12 months prior to arrival at RR. Please send the signed form to us at rrmc@rockyridge.org no later than 2 weeks before the start of your child's program.

STUDENT FULL NAME: DATE OF BIRTH:

MEDICAL PERSONNEL:

Please review this student's HEALTH HISTORY and MEDICATION FORMS and complete all remaining sections of this MEIDCAL EXAMINATION FORM. A licensed physician's signature is required at the bottom of this form.

DATE OF MOST RECENT PHYSICAL EXAM (must be within past 12 months): _____

WEIGHT:_____lbs HEIGHT:_____ft_____in BLOOD PRESSURE:_____/_____

	Normal	Abnormal	Explain Abnormalities
Eyes	☐	☐	
Ears/Nose /Throat	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	

	Normal	Abnormal	Explain Abnormalities
Genitalia/hernia	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Other	☐	☐	

ALLERGIES:

☐ No known allergies

☐ To FOODS (please list all food allergies): _____

☐ To MEDICATIONS (please list): _____

☐ To ENVIRONMENT (please list): _____

☐ OTHER (please list): _____

☐ This student is allowed to carry ☐ Epi-Pen ☐ Inhaler as specified on Medication Form

Recommendations/Restrictions While Patient is at Rocky Ridge Music (altitude 9,200 ft):

This student will take the following medications while at camp (please list name, dose, and frequency): _____

_____

This student is undergoing treatment at this time for the following conditions: ☐ None or please describe:_____

_____

The following activities are those in which the student may participate during the seminar. Do you recommend that the student be allowed to participate in each activity?

Mountain Hiking ☐ Yes ☐ No Basketball ☐ Yes ☐ No

Please list any physical conditions that would require special care or limit activity:

Please list any additional activities that should be restricted:

I have reviewed the HEALTH HISTORY FORMS and MEDICATION FORMS (including the list of allowed over-the-counter medications) and have discussed the RRM program with the student and/or the student's parent/guardian. It is my opinion that the student is physically and emotionally fit to participate in an active camp program at 9,200 ft elevation except as noted herein.

Name of Licensed Provider (print): Phone:

Office Address:

SIGNATURE OF PROVIDER: DATE:

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: _____

(Optional) I authorize my/my student's school to share my/my student's immunization records with state/local public health agencies and the Colorado Immunization Information System, the state's secure, confidential immunization registry.

Parent/Guardian/Student (emancipated or over 18 yrs old) signature: _____ Date: _____

Last Reviewed: October 2018