

**MEDICAL EXAM**  
**TO BE COMPLETED BY PHYSICIAN**

Please return this form to : Katie Radeke, GFF Camp 507 Huntington Dr S. Sartell, MN 56377

Name of Camper – Last, First, Middle \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of Examination \_\_\_\_\_

Diagnosis and Physical Disability \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Positive Physical Findings \_\_\_\_\_

List all medications the camper is now taking. Please indicate which will be necessary during the camp session.

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____

Describe any allergies/sensitivities: \_\_\_\_\_

Give details of any special concerns (decubitus ulcers, open sores, catheters, irrigations, ear tubes, enemas, medically prescribed diet, etc.) \_\_\_\_\_

List exercise or therapy required during camp session \_\_\_\_\_

List restrictions:  No swimming  No outside overnights  Other (specify) \_\_\_\_\_

Does camper have a history of seizures?  yes  no *If yes, please fill out information below. If no, skip this section.*

Date of last seizure \_\_\_\_\_ Type \_\_\_\_\_ Frequency of occurrence \_\_\_\_\_

Medically controlled?  yes  no

Date of last tetanus toxoid \_\_\_\_\_ *Should be administered with this physical if not up to date.*

Current tuberculosis test result & date (must be within 2 years) \_\_\_\_\_

Chest x-ray results if positive mantoux \_\_\_\_\_

**THIS FORM MUST BE SIGNED BY PHYSICIAN**

Print Physician's Name \_\_\_\_\_ Physician Signature \_\_\_\_\_

Current Address \_\_\_\_\_ Number and Street or Route \_\_\_\_\_ City/State/Zip \_\_\_\_\_ Phone \_\_\_\_\_

**FOR COURAGE CAMPS USE ONLY**

Admission Date \_\_\_\_\_ Temperature \_\_\_\_\_ Pulse \_\_\_\_\_

# HEALTH FORM

## TO BE COMPLETED BY CAMPER

**GENERAL INFORMATION** (Please Print)

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Name of Applicant – Last, First, Middle      Age      Sex      Date of Birth (M/D/Y)

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Current Address    Number and Street or Route      City/State/Zip

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Home Phone (include area code)      Work Phone (if applicable, include area code)

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Emergency Contact Name      Relationship to Applicant

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Home Phone (include area code)      Work Phone (include area code)

**MEDICAL INFORMATION**    *please attach extra sheet if additional space is needed*

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List all type(s) of physical disability (including Deaf/HOH)      Date of onset

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List operations/serious illnesses/injuries with approximate dates

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List any other disorders (communication disorders, mental disabilities, emotional disorders, learning disabilities, etc.)

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Primary Care Physician Name    Address      Phone Number (include area code)

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Specialist Name (if applicable)    Phone Number (include area code)      Recommendations

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List Restrictions/Special Needs (if any)

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List diet modification (if any, please include gluten-free diet)

**HEALTH HISTORY**    *Check all that apply and give approximate dates*

Frequent Ear Infections \_\_\_\_\_     
 Mononucleosis \_\_\_\_\_     
 Hay Fever \_\_\_\_\_  
 Heart Defect/Disease \_\_\_\_\_     
 Chicken Pox \_\_\_\_\_     
 Poison Ivy \_\_\_\_\_  
 Convulsions \_\_\_\_\_     
 Measles \_\_\_\_\_     
 Insect Sting \_\_\_\_\_  
 Diabetes \_\_\_\_\_     
 German Measles \_\_\_\_\_     
 Asthma \_\_\_\_\_  
 Bleeding Disorder \_\_\_\_\_     
 Mumps \_\_\_\_\_     
 Medications \_\_\_\_\_  
 Hypertension \_\_\_\_\_     
 Allergies \_\_\_\_\_     
 Other \_\_\_\_\_

**Immunizations**      **Menstrual History (females only)**

Are immunizations up to date?     yes     no      Has camper begun menstruation?     yes     no

List Dates of last booster:      Has she been informed about menstruation?     yes     no

no

DTP \_\_\_\_\_ MMR \_\_\_\_\_      Special considerations/irregular menstrual patterns

Polio \_\_\_\_\_ Other \_\_\_\_\_