PHYSICAL EXAMINATION

This Physical Examination form must be completed and *signed by a Licensed Physician*.

We request this form or a copy of a physical dated no more than **24 months** from your camp date to participation in camp. Returning campers with a physical on file less than 24 months old do not need a new physical.

Name:____ Date of Birth____/____/____ Male____ Female____
Last First Middle Initial

Diagnosis:____

Is any condition present, which may result in an emergency? Please describe:____

____

Allergies:____

EXAMINATION COMPLETED BY DOCTOR

Height: Weight:	Ideal Body Weight:
Pulse: BP: Temp:	Lungs:
Head/Scalp:	Cardiac:
Eyes:	Upper Extremities:
Vision:	Lower Extremities/Edema/Circulation:
Ears/Hearing:	Back/Spine:
Mouth/Throat/Nose:	Perineum:
Neck/Thyroid & Lymph Sys:	Skin:
Nervous System/Pupil Reaction/Reflexes/Gait/Sensations:	
Abdomen:	Free from communicable disease: YES / NO

PREVIOUS ILLNESS (give age when these occurred): Chicken Pox_________________ Measles________________
Mumps_________________ Scarlet Fever___________________ Other____

IMMUNIZATION HISTORY: Please give dates (month/year) of immunizations and most recent booster dates:
Date of last booster: DPT_________ MMR__________ Tetanus ____________ (update if not current)
All vaccinations are up to date ___ Yes ____ No If no please explain reason: ____

ACTIVITY RESTRICTIONS:

List any conditions, operations or known serious injury that may affect activity level:____

Are there medical reasons to restrict this person from participating in an overnight camp out? (i.e. sleeping in a tent or on the ground?)
No_____ Yes_____ if Yes, please explain____

Are there medical reasons to limit or restrict this individual from participating in the swimming program?
No_____ Yes_____ if Yes, please explain____

Please list any other activity restrictions while individual is participating in camp.

____

In the past year, has client's health status changed? No_____ Yes_____ If Yes, please describe_______________________________
Is this client on medication? ____ No ____ Yes, current medication list attached or listed below

Medication:	Reason for use:	mg.	# tabs	Frequency	Brkfst	Lunch	Dinner	Bed	Special Instructions: before, with or in food/crushed
	for:								
	for:								
	for:								
	for:								

Examining Physician's Name (please print)____
Signature____Date_________________________
Address____Phone (_____)_________________________
City/State/Zip____

HEALTH HISTORY

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

A health history is required to be completed annually

Please bring along a copy of applicant's insurance card at time of check-in at camp

APPLICANT INFORMATION

Applicant Name: ____
Last First MI

Date of Birth: ____________________ Age: _______ Sex: ____________ Height: ________ Weight: _____________
MM/DD/YYY

Address: ____
Number and Street City/State/Zip

Primary Phone: ______________________________ Secondary: ___________________________________

Allergies: (please list ALL): ____

Does applicant carry an Epi-pen ___ Yes ___ No Does applicant carry an inhaler ___ Yes ___ No

Please list any physical or developmental disabilities: ___________________________________

____

Please list any special dietary needs:____

Menstrual History (Females Only) Has individual begun menstruation ___ Yes ___ No

If yes is the individuals cycle regular ___ Yes ___ No Does individual anticipate having during camp ___ Yes ___ No

Has individual received education about menstruation ___ Yes ___ No

How does applicant take medications: (please answer even if not bringing scheduled medications to camp)

___swallows whole with water ___break in half and swallows with water ___whole in applesauce or pudding ___cut in half in applesauce or pudding ___crush meds in applesauce or pudding ___uses oral syringe (please send) ___uses medicine spoon (please send) ____other, explain: ________________________________

Medication: **Reason for use:**	mg.	# tabs	Frequency	Brkfst	Lunch	Dinner	Bed	Special Instructions: before, with or in food/crushed
for:								
for:								
for:								
for:								
for:								

Emergency contact

Name: ____________________________________ Relationship to applicant: ___________________________

Primary Phone: ______________________________ Secondary Phone: _______________________________

I the undersigned attest that the information above is true and accurate to the best of my knowledge.

Signature of parent or legal guardian: ____