PHYSICAL EXAMINATION & HEALTH HISTORY
Day Camp Only

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

We request this form to be completed no more than 1 year from your camp date to participate in camp.
Please bring along a copy of the camper's insurance card at time of check-in at camp
Please mail the completed form to:
Nicole Hart, Camp ROCK Nurse 15616 Boulder Creek Drive, Minnetonka, MN 55345

Camper's Legal Name:	DOB:	
Camper's Preferred Name:	Age (as of today):	Sex:
Address:	Pronouns:	
Primary Phone Number:	Secondary Phone Number:	

EXAMINATION COMPLETED BY DOCTOR

Diagnoses: Is any condition present, which may result in an emergency? Please describe:	
Allergies:	
Does this person carry an Epi-pen? YES / NO	Does this person carry an inhaler? YES / NO

Height: Weight:	Lungs:
Pulse: BP: Temp:	Cardiac:
Head/Scalp:	Upper Extremities:
Eyes:	Lower Extremities/Edema/Circulation:
Vision:	Back/Spine:
Ears/Hearing:	Skin:
Mouth/Throat/Nose:	Nervous System/Pupil Reaction/Reflexes/Gait/Sensations:
Neck/Thyroid & Lymph Sys:	
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)
COVID-19: 1st Dose_____ 2nd Dose_____ Booster (if applicable)_____
All Vaccinations are up to date ___ Yes ____ No
If no please explain reason: _____

Camper: _____ DOB:___ /___/____

ACTIVITY RESTRICTIONS:

List any conditions, operations or known serious injury that may impact camp participation:	
	Yes/ No If yes, please Explain:
Are there medical reasons to limit or restrict this individual from participating in the swimming program?	Yes/ No If yes, please Explain:
Please list any other activity restrictions while individual is participating in camp:	

By signing below, I, the camper's physician, certify that the information provided is accurate to the best of my knowledge.

Physician's Signature: _____

Name (Please Print)	Date:
Address:	Phone: