

RESIDENT CAMP HEALTH PHYSICAL EXAMINATION

Confidential Information. Must be signed for participation.

Participant's Name: _____ Age: ____ Date of Birth: _____
(First name, Last name)

Camp Name: _____ Program Name: _____ Program Dates: _____

TO BE COMPLETED BY LICENSED PHYSICIAN:

I have examined the above participant within the past two years. Date of Examination: _____

Height: _____ Weight: _____ Temperature: _____ B/P: _____

Check = Normal. If abnormal, please describe:

Medical

- Appearance _____
- Skin _____
- Eyes _____ (Corrected vision: Yes No)
- Ears _____
- Nose _____
- Dental/Oral _____
- Heart _____
- Lungs _____
- Abdomen _____

Musculoskeletal

- Neck _____
- Back _____
- Shoulder/Arms _____
- Elbow _____
- Wrist/Hand/Fingers _____
- Hips/Legs _____
- Knee _____
- Ankles/Feet/Toes _____
- Other _____

Current Health Status:

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies: _____ Allergy Action Plan <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please attach) |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma: _____ Asthma Action Plan <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please attach) |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure disorder/Epilepsy: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Reported loss of consciousness or concussion: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (please specify): _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Current treatment(s) and/or medication(s): _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other conditions(s) that the camp health supervisor or staff should be made aware of: _____ |

- This participant is fully able to participate in an overnight camp program without restrictions.
- This participant is able to participate in an overnight camp program with the following restrictions/recommendations: _____

Licensed Physicians Signature: _____ Printed Name or Stamp _____

Date: _____ Address: _____

Phone Number: _____

Initials if completed by nurse or physician assistant: _____