girl scouts of greater chicago and northwest indiana

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 on the line provided.

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 _____

Check yes or no as appropriate.

Yes	No		
☐	☐	Allergies: _____	Allergy Action Plan ☐ Yes ☐ No (If yes, please attach)
☐	☐	Asthma: _____	Asthma Action Plan ☐ Yes ☐ No (If yes, please attach)
☐	☐	Diabetes: _____	
☐	☐	Seizure disorder/Epilepsy: _____	
☐	☐	Reported loss of consciousness or concussion: _____	
☐	☐	Other (please specify): _____	
☐	☐	Current treatment(s) and/or mediation(s): _____	
☐	☐	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: _____ Date: _____

Printed Name _____ Phone Number: _____

Address: _____

Initials if completed by nurse or physician assistant: _____