

Date of Physical Exam



Physician's Stamp and Signature:

PHYSICAL EXAMINATION

To be filled out by your physician. Campers will not be permitted to attend camp unless this form is completed and returned before the first day of camp.

Campers Name _____ Birth Date ____/____/____

PHYSICAL CONDITION: Height _____ Weight _____ Blood Pressure _____

Camper is under the care of a physician for the following condition(s) _____

CURRENT TREATMENTS (INCLUDE MEDICATIONS): _____

LIST ALL FOOD AND/OR DRUG ALLERGIES: _____

PHYSICAL EXAM:

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Brachial artery blood pressure | <input type="checkbox"/> Excessive, unexplained exertional dyspnea or fatigue |
| <input type="checkbox"/> Physical Stigmata of Marfan syndrome | <input type="checkbox"/> Exertional chest pain/discomfort | <input type="checkbox"/> Elevated blood pressure |
| <input type="checkbox"/> Femoral vs. radial pulses to exclude aortic coarctation | <input type="checkbox"/> Syncope/nears syncope | |
| | <input type="checkbox"/> Prior recognition of a heart murmur | |

FAMILY MEDICAL HISTORY:

- | | |
|--|---|
| <input type="checkbox"/> Premature death related to cardiovascular disease | <input type="checkbox"/> Hypertrophic cardiomyopathy, dilated cardiomyopathy, marfan syndrome, arrhythmias, channelopathy (eg. Long QT) |
| <input type="checkbox"/> Disability from cardiovascular disease at age 50+ | |

This camper was examined by me and was found to be in good general health and able to participate in all athletic programs. Yes No If No please explain. _____

Camper Immunization History

Please record the date (month and year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunization	Year of Last Booster
DPT Series, Diphtheria, Pertussis, Tetanus OR	1	1
	2	2
	3	3
TD Series, Tetanus, Diphtheria OR		
Tetanus		
Polio Series		
MMR Series		
HIB Series		
Hepatitis B Series		
Chicken Pox (illness or vaccine)		
Meningitis		



AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

All Medications both prescription and non-prescription must be brought to the camp infirmary (Room 131 in the Physical Education Building) along with this authorization form filled out by you the parent and by your child's physician.

Prescription medication must be in the original prescription bottle with your child's name on it.

Campers are at NO time allowed to carry medication with them.

TO BE COMPLETED AND SIGNED BY PARENT OR GUARDIAN:

I request that my child (**Campers Name**) _____ Birth Date ____/____/____ receive the medication as prescribed on this form by our licensed health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the camp nurse or other assigned person will administer the medication.

Signature (Parent/Guardian) _____ Date _____

TO BE COMPLETED AND SIGNED BY PHYSICIAN:

Recommendations and restrictions while at camp:

Patients Name _____

Name of medication(s): _____

Dosage: Amount(s) to be given: _____

Time(s) to be given: _____

Side effects: To report: _____

To expect: _____

Diagnosis: _____

Physician's Information:

Signature: _____

Address _____

Phone number _____

Physician's Stamp:

Date of form completion _____