

SUMMER 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 Exam:** _____

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: _____
- Mental illness (including depression, anxiety, eating disorders): _____
- Current treatment(s) and/or medication(s): _____
- Other conditions(s) that the camp health supervisor or staff should be made aware of: _____

This participant is fully able to participate in a camp program without restrictions.

This participant is able to participate in a camp program with the following restrictions/recommendations: _____

Licensed Physicians Signature: _____ Date: _____

Printed Name _____ Phone Number: _____

Initials if completed by nurse or physician assistant: _____