Camper Physical

TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER (M.D., N.P., P.A., D.O.)

Camper's Name: ____ Date of Exam: __________________

History of reaction to food, serum, drugs or medications? ____ Yes ____ No

Explain: ____

Sex: __________ Age: ________ Height: _______ Weight: _______ B/P:______ Pulse: ______ Resp_______

Visual Impairment? Yes ____ No______

Hearing: Right normal? Yes_____ No______ Left normal? Yes _____ No _____

Impairment: ____

Immunization History:

Date (month/year) of most recent tetanus shot: ____

Has patient completed the immunizations that were required for school attendance? ☐ Yes ☐ No

System	Satisfactory	Unsatisfactory	Describe Abnormalities
Skin, Lymphatic			
Eyes			
Ears			
Mouth			
Nose, throat			
Neck, thyroid			
Chest, breasts, lungs			
Heart rate/rhythm			
Heart murmur (describe)			
Abdomen, liver, kidneys, spleen			
Extremities (back, spine)			
Joints			
Neurological			
Psychological			

Current Diagnosis(ses): ____

____

The following abnormalities should be noted: ____

____

The camper: ______does ______does not, have a history of emotional, psychological or psychiatric disturbance.

____

Applicant may participate in camp activities: ____ with restriction ____ without restriction

Camper should not participate in sports. Reason for limiting activity: _______________________________________

Please note: All Camp Millhouse activities are modified for each camper's individual abilities.

The following non-prescription medications may be stocked in the camp Health Center and are used on an as-needed basis to manage illness and injury. Please cross out those medications the camper should NOT be given.

Acetaminophen/Tylenol
Benadryl
Chloroseptic Throat Spray
Cough Drops
Imodium
Ibuprofen/Advil
Tums

Milk of Magnesia
Robitussion/Guaifenesin
Sudafed PE/Phenylephrine
Aloe Gel/Lotion
Triple Antibiotic Ointment
Bandaid Antiseptic Wash
Hydrocortisone Ointment

Calamine Lotion
DEET-Free Insect Repellent
Sunscreen
Tinactin
Artificial Tears

Health Care Provider (please print):

Name: ____

Address: ____

Phone: ____

Signature of Physician: ____ Date: ________________

(Original signature required-no stamps)