



# Camp Modin

## PHYSICAL EXAMINATION FORM FOR CAMPERS & STAFF (Form 2B)

Please complete this form and return it to:  
Camp Modin, 401 East 80th Street Suite 28EF, New York, NY 10075 (before May 15)  
or Camp Modin, Modin Way, Belgrade, ME 04917 (after May 15)

*For Camp Use Only*

Received \_\_\_\_\_

Cabin \_\_\_\_\_

Session \_\_\_\_\_

Processed \_\_\_\_\_

**This section must be completed by the parent/guardian of a currently enrolled camper OR by a staff member.**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Birthday (month/day/year) \_\_\_\_\_ Age At Camp \_\_\_\_\_ Gender:  Male  Female  
 Home Address \_\_\_\_\_  
 City \_\_\_\_\_ State/Province \_\_\_\_\_  
 Zip/Post Code \_\_\_\_\_ Country (if other than US) \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Emergency Contact Number \_\_\_\_\_

**The rest of this form MUST be completed by a licensed medical provider.**

Physical exam done today:  Yes  No If "no", date of last physical: \_\_\_\_\_  
 Weight: \_\_\_\_\_  lbs  kgs Height: \_\_\_\_\_  ft/in  cm Blood Pressure: \_\_\_\_/\_\_\_\_

### Immunization History

Provide the month & year for each immunization below. Starred (★) immunizations must be current.  
Copies of immunization forms from your health-care provider are acceptable.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diphtheria, tetanus, pertussis★ (DTaP) or (TdaP)						
Tetanus Booster★ (dT) or (TdaP)						
Mumps, measles, rubella★ (MMR)						
Polio★ (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)	<input type="checkbox"/> Had chicken pox Date: _____					
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) test	Date: _____	<input type="checkbox"/> Negative <input type="checkbox"/> Positive				

**OVER PLEASE**

**Please have a licensed medical provider complete this section & sign below.**

**ALLERGIES**

No Known Allergies    Foods    Medications    Environmental    Other

**List all allergies below and describe previous reactions:**

**DIET & NUTRITION**

No Restrictions    Has the following dietary restrictions (**describe below**):

**CURRENT TREATMENT**

None    This individual is undergoing treatment at this time for the following conditions (**describe below**):

**SUMMER MEDICATIONS**

Takes no medications    Will take the following prescribed medication(s) at camp (**list name, dose & frequency**):

**SUSPENDED MEDICATIONS**

Does this individual take medications during the year that will be suspended at camp?    Yes    No (**if "yes" please list**):

**CONTINUED TREATMENT**

None needed    This individual will have the following treatments continued while at camp (**describe below**):

**LIMITATIONS**

Will this individual require any limitations or restrictions to activity while at camp?    Yes    No (**if "yes" please detail**):

**ADDITIONAL INFORMATION**

Use this space to provide any additional information about this individuals behavior and physical, emotional or mental health about which the camp should be aware.

**"It is my opinion that this individual is physically and emotionally fit to participate in an active camp program except as noted above."**

Name of licensed provider (*please print*) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip/Post Code \_\_\_\_\_ Country (*if other than US*) \_\_\_\_\_ Phone \_\_\_\_\_