PHYSICAL EXAMINATION FORM FOR CAMPERS & STAFF

Please scan and email this form to: modin@modin.com OR mail it to our office at:
401 East 80th Street 28EF, New York NY 10075 or 51 Modin Way, Belgrade ME 04917 *(after May 15)*

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 (★) items are MANDATORY and 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
Mumps, measles, rubella (MMR) ★ MANDATORY						
Polio (IPV) ★ MANDATORY						
Diptheria, tetanus, pertussis (DTaP) ★ MANDATORY						
Tetanus, diptheria & acellular pertussis (Tdap) - Tetanus booster						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ❑ Had chicken pox Date:						
Meningococcal B (meningitis)						
Human papillomavirus (2vHPV, 4vHPY or 9vHPV)						

Tuberculosis (TB) test	Date:	❑ Negative ❑ 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 ___________________________