PHYSICAL EXAMINATION FORM FOR CAMPERS & STAFF

THIS FORM MUST BE UPLOADED TO THE DOCTOR FORM (PHYSICAL EXAM) SECTION YOUR ONLINE GET READY ACCOUNT. FORMS MAY NOT BE SEND VIA EMAIL.

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 _____